**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27001

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Data of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Mary | Lucas | 8 / 7 / 01 | 9:07 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Ft. Washington Hospital | Ft. Washington | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-30-2027 | 1☐M 2☒F | 90 Yrs. | | | Dec. 2, 1910 | Culpepper, VA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| D.C. | N/A | Washington | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3552 10th St. N.W. | 20010 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Detas: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| 12th | | Food Services | GSI |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surneme) |
|---|---|
| Daniel White | Nora Phillips |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Margaret B. Gooch/Niece | 40 Beaumont Rd. Silver Spring, MD. 20904 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify) | Lincoln Cemetery | 8-14-2001 | Suitland, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ J. P. Marshall | Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in deeth) a. | pneummia | 1 week |
| Due to (or as a consequence of): | Alzheimers Disease | 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last b. | | |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? | 23c. If yas, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal daeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the causa(s) and mannar statad.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ William J. Tanner MD | D35206 | August 7, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William T. Tanner MD 11301 Livingston Rd. Ft. Wash. MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ Lenora B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item#8 PerFH
Amend Item #1 Per FH 8-10-01 HCHD TH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 27002
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Sylvia | Lucinda | Myers | 8 | 3 | 01 | 8:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Brightview Assisted Living | Bel Air Md. | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 201-03-1471 | 1☐ M 2☒ F | 82 Yrs. | | | | | March 31, 1919 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | ---------- | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2300 Essex Street | 21224 | USA |

| 11. Meritel Stetus | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, atc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Nama (First, Middle, Maiden Surname) |
|---|---|
| George (u/k) Bachman | Mary (u/k) Saltzman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| H. Lamar Myers / Son | 2515 Boston St. Condo 1005, Baltimore, MD 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Tohickon Union Cemetery | 8-11-01 | Weisel, Pennsylvania |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac arrest | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. DM2 | |
| | Due to (or as a consequence of): | |
| | c. HTN | |
| | Due to (or as a consequence of): | |
| | d. CHF | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Gillian Adams | D42204 | 8/5/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gillian Adams, MD - 104 Plumtree Rd., Bel Air, MD 21015

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 27003

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Doris McGhee

2. Date of Death — Month: 07 Day: 31 Year: 2001

3. Time of Death: 9:55AM

4a. Facility Name *(If not institution, give street and number)*: Springbrook Adventist NSG Home

4b. City, Town, or Location of Death: Silverspring MD.

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 238448946

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 8/15/31

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: capital Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7601 Millwright Street

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance

16b. Kind of Business/Industry: Bureau Of Engraving & Printing

17. Father's Name *(First, Middle, Last)*: Oliver Fowler

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Robinson

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Eric L. Lassiter (Nephew)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 48 Palm Street Newark, NEW JERSEY 07106

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: National Harmony Memorial Park

Date: 8/4/01

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. Washington, D.C. 20019

**Physician /Medical Examiner**

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Pleural Effusions — 1 mo

Due to (or as a consequence of):

b. Chronic Renal Failure — Many yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Cardiomyopathy, Recent Sepsis, Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart Turkewitz

29c. License number: D31001

29d. Date signed *(Month, Day, Year)*: 7/31/01

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): Stuart J. Turkewitz, MD 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 06 2001

32. Registrar's Signature: Lauren D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 23a.Part1 PGC Per Phys.8-6-01 cr

# Certificate of Death

Reg. No. 2001 27004

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Susie | D. | Mitchell | August 2 2001 | 4:28 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Southern Maryland Hospital | Clinton | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 407-66-1608 | 1☐M 2☐F XX | 70 Yrs. | | | July 26 1931 | Ohio |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | White Plains | 1☒Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10720 Hart Place | 20698 | US |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed X 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | 0 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Steve Davis | Mary Davis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James Mitchell (Son) | 4612 Backlick Rd. Anandale, VA 20030 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) XX | Evergreen Cemetery | 8/7/01 | Louisville, KY |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Julian Rent | Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebro vascular accident | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. massive heart attack ~~(Myocardial infarction)~~ | 2 days |
| | Due to (or as a consequence of): c. Myocardial infarction | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Previous Myocardial infarction
bilateral Carotid endarterectomy

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Rointan Farahifar M.D. | D43446● | 8/2/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROINTAN FARAHIFAR M.D. 9801 Georgia Ave suit 3-35 SILVER SPRING MD 20902

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 06 2001 | ▶ Jennifer G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

MITCHELL, SUSIE @ 1528 - 8-2-01 cr DR. FARAHIFAR ME# 469421

(8)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27005

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VARICE O. McCAISON

2. Date of Death Month August Day 4, Year 2001

3. Time of Death: 1:05 A M

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 578-20-1455

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-11-22

9. Birthplace *(State or Foreign Country)*: Wash. D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 310 Milfan Drive

10f. Zip Code: 20743

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Private Cook

18b. Kind of Business/Industry: Private Home

17. Father's Name *(First, Middle, Last)*: Bose Waller

18. Mother's Name *(First, Middle, Maiden Surname)*: Geneva Hooks

19a. Informant's Name/Relationship *(Type, Print)*: Janice Edwards / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6012 Wesson Drive, Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery — Date: 8- 9 - 01

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Emil D. Strickland

22. Name and Address of Facility: Strickland Funeral Services.PA 6500 Allentown Rd, Camp Springs, MD 20748

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension

Due to (or as a consequence of):

c. End Stage Renal disease

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Rahimian

29c. License number: D05299M44839

29d. Date signed *(Month, Day, Year)*: 8/4/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ali Rahimian , 1328 Southern Ave., SE, Wash. D. C. 20032

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 07 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**State Registrar**

(2)

McCaison, Varie 8-4-01 @ 0105

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27006

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Year | 3. Tima of Death |
|---|---|---|
| Zelma D. McCarrell | August 6, 2001 | 9:28 A M |

| 4a. Facility Name (If not institution, giva street and number) | 4b. City, Town, or Location of Daath | 4c. County of Deeth |
|---|---|---|
| Fort Washington Hospital | Ft. Washington | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 525-14-9216 | 1☐ M 2☒ F | 100 Yrs. | | | April 22, 1901 | Texas |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Maryland | Prince Georges | Fort Washington | 1☐ Yas 2☒ No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizan of Whet Country? |
|---|---|---|
| 220 Emerald Hill Drive | 20744 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Raca - Amaricen Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas: | 1☐ Yas 2☒ No Specify: | Specify: African American |

| 15. Decedent's Education (Specify only highast grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Physical Therapist | Healthcare |

| 17. Fathar's Name (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maidan Sumame) |
|---|---|
| Edward Matthew Gafford | Carrie Bernice Robinson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) |
|---|---|
| Travis M. Gafford/Nephew | 220 Emerald Hill Dr., Ft. Washington, MD 20744 |

| 20a. Method of Disposition | 20b. Place of Disposition (Nama of cematary, crematory or other place) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Othar (Specify) | Hillcrest Memorial Gardens | 8/10/2001 | Las Cruces, New Mexico |

| 21. Signature of Funaral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| George P. Kalas | George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach line.

| | | Approximate Interval Batween Onsat and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Fatal Arrythmia | 1 hour |
| Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Dua to (or as a consequence of): b. | Underlying Coronary Artery Disease | 30 yrs |
| Dua to (or as a consequence of): c. | | |
| Dua to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yas, outcoma of pregnancy | 23d. Date of dalivary Month Day Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Liva birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at lima of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

Congestive heart failure, generalized arteriosclerotic cardiovascular disease

| 23a. Did tobacco usa contributa to tha causa of daath? | 24a. Was an autopsy performad? | 24b. Wara autopsy findings available prior to completion of ceusa of daath? |
|---|---|---|
| 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown | 1☐ Yas 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referrad to medical examiner? | 26. Placa of Daath (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurrad |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yas 2☐ No | |

| 28a. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) | 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, date and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the ceusa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| Richard A. Farson MD | DO 2237 MD | 8/6/01 |

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

Richard A. Farson MD 12825 Old Fort Rd. Ft. Wash. MD 20744

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 07 2001 | G. Spirito |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. **Important: If Item 27 is marked othar than "natural", or Itams 23e or 28a-f show sny injury or other traumatic avant, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27007

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Harry Lee McKinzie
2. Date of Death (Month, Day, Year): August 04, 2001
3. Time of Death: 01:50 PM
4a. Facility Name (If not institution, give street and number): 6308 Carrington Court
4b. City, Town, or Location of Death: Capitol Heights
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 243-38-5841
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/05/1930
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6308 Carrington Court
10f. Zip Code: 20743
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): Albert McKinzie
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Ellen Worthington

19a. Informant's Name/Relationship (Type, Print): Terry McKinzie - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6308 Carrington Court, Capitol Heights, MD 20743

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 08/11/01
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fort Lincoln Funeral Home 3401 Bladensburg Road, Brentwood, MD 20722

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cirrhosis — 2 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [XX] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Singh MD
29c. License number: D45660
29d. Date signed (Month, Day, Year): August 07, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Dpinder Singh, 14300 Gallant Fox Lane, Suite #124, Bowie, Maryland 20715

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27008

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MAE JEWELL McDOWELL
2. Date of Death Month / Day / Year: August 8, 2001
3. Time of Death: 8:40AM
4a Facility Name *(If not institution, give street and number)*: 4413 Rena Road #102
4b. City, Town, or Location of Death: Suitland
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 577-74-1381
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/9/36
9. Birthplace *(State or Foreign Country)*: Alabama

Usual Residence of Decedent

10a. State: Md
10b. County: Prince Georges
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4413 Rena Road #102
10f. Zip Code: 20746
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Private Duty

17. Father's Name *(First, Middle, Last)*: James C. Glover
18. Mother's Neme *(First, Middle, Meiden Surname)*: Hattie Pierce

19a. Informent's Neme/Relationship *(Type, Print)*: James McDowell/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4413 Rena Road #102 Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Washington National Cemetery
Date: 8/13/01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funerel Service Licensee: ▶ Sonya Montgomery-Cheatham
22. Name and Address of Facility: Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Squamous Cell Cancer of Left Lung, Stage IV — 2 months

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Right Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D14730
29d. Date signed *(Month, Day, Year)*: 8/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kai-Yin Yeung, MD 8926 Woodyard Rd Suite 201 Clinton, MD 20735

**State Registrar**

31. Date filed *(Month, Dey, Year)*: AUG 09 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

(4)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27009

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| James Meredith III | August 3, 2001 | 8:30AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-86-1035 | 1☒M 2☐F | 44 Yrs. | | | June 24, 1957 | Austin, TX |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince Georges | Landover Hills | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5408 76th Ave. | 20784 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Custodian | Apt. Building |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James L. Meredith Jr. | Sally Carter |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Janice Meredith/Sister | 5408 76th Ave. Landover Hills, MD. 20784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MD. Veterans Cem. | 8-13-2001 | Cheltenham, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ J. P. Marshall | Marshall's Funeral Home, Inc. 4217 9th St. NW Washington, DC 20011 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cirrhosis of Liver | 1 Month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23a. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D 24721 | 8/3/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed Sadiq, M.D. 14333Laurel Bowie Rd. Laurel, MD. 20708

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ |

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 23a.Part II Per Phys.PGC 8-10-01 CF

# Certificate of Death

Reg. No. 2001 27010

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Christine Malcom | July 23, 2001 | 12:27PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Fort Washington Hospital | Fort Washington | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 235-64-1021 | 1☐M 2☒F | 84 Yrs. | | | March 20,1917 | Alabama |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Prince Georges | Clinton | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9318 Pella Place | 20735 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Domestic | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Champ Clopton | Nettie Staton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ida M. Caple/daughter | 9318 Pella Place Clinton, Maryland 20735 |

| 20a. Method of Disposition | 20b. Pleca of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Resurrection Cem. | 7/28/01 | Clinton, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Leroy Hodges | Hodges & Edwards F.H. 3910 Silver Hill RD. Suitland, MD. 20746 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Ca of lung

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. HTN

Due to (or as a consequenca of):

c. Alzheim

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in tha past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown | 23d. Dete of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

Left Sholder Fracture of Humerus

| 23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown | |
|---|---|
| 24e. Was an eutopsy performed? 1☐Yes 2☒No | 24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No |

| 25. Wes case referred to medical examiner? 1☐Yas 2☒No | 28. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |
|---|---|

| 27. Manner of Deeth | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) end manner es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to tha causa(s) and menner stated.

| 29b. Signature and title of certifier | 29c. Licanse number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| ▶ K. Davachi M | D25640 | 7/24/01 |

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Khosrow Davachi 1328 Southern Ave., S.E. Suite 301 Wash., D.C. 20032

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ Bonnie B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

Dierdra Meyers
CJ
Unknown 01-201
01-4452-003

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27011

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dierdra Lorreese Myers

2. Date of Death: Month: August; Day: 06; Year: 2001

3. Time of Death: 04:09 A.M.

4a. Facility Name (If not institution, give street and number): Baltimore-Washington Parkway northbound/South of I-95

4b. City, Town, or Location of Death: Hanover

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 193-40-4398

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-07-52

9. Birthplace (State or Foreign Country): Philadelphia, PA

Usual Residence of Decedent

10a. State: PA

10b. County: Philadelphia

10c. City, Town or Location: Philadelphia

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5410 Sycamore Street

10f. Zip Code: 19120

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1/7/73--1977

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correctional Officer

16b. Kind of Business/Industry: Philadelphia Prison System

17. Father's Name (First, Middle, Last): George Myers, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Verdina Carolina Murph Myers

19a. Informant's Name/Relationship (Type, Print): Malaika T. Myers-Thomas/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2603 Phipps Avenue, Willow Grove, PA 19090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 8/10/01

20c. Location - City or Town, State: Beltsville, MD 20705

21. Signature of Funeral Service Licensee: ▶ Larry L. Simmons

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD 20747

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 8/6/01

28b. Time of Injury: 4:05 A. M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject was driver of motor vehicle involved in a collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Highway - Northbound 295

28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore-Washington Parkway Anne Arundel County, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen R. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001

32. Registrar's Signature: ▶ Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27012

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Chancey | McQueen | August 7, 2001 | 6:00AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 579-54-2274 | 1☒M 2☐F | 59 Yrs. | | | | | March 27, 1942 | Rocky Mount, NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| District of Columbia | | Washington | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 920 Division Avenue, NE | 20019 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2½ years | Electrician | Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Viola McQueen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mildred I Mims - Sister | 5715- 83rd Pl. New Carrollton, MD 20784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify) | Lee's Crematory | August 14, 2001 | Clinton, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Stewart Funeral Home, Inc.
4001 Benning Road, NE Wash. D.C. 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AND COMPLETE AUTOPSY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | 042249 | 8/8/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAYMOND MUADIAMBO 9831 GREENBELT RD STE 101 LANTHAM MD 20706

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0058.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(5)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27013

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Janet M. Molly

2. Date of Death: Month August Day 13 Year 2001

3. Time of Death: 0913

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 181-22-2424

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/18/1931

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1135 Deer Park Rd.

10f. Zip Code: 21157

10g. Citizen of What Country? US

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aide

16b. Kind of Business/Industry: Mental Hospital

17. Father's Name (First, Middle, Last): Morris Richardson

18. Mother's Name (First, Middle, Maiden Surname): Anna McClaine

19a. Informant's Name/Relationship (Type, Print): Edwin Steiger (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1135 Deer Park Rd., Westminster, Md. 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cape Henlopen crematory

Date: 8-14-01

20c. Location - City or Town, State: Frankford, Delaware

21. Signature of Funeral Service Licensee: Mark Burbage M00701

22. Name and Address of Facility: The Burbage Funeral Home, 108 William st., Berlin, Md. 21811

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | 2 days |
| Due to (or as a consequence of): b. | Coronary Artery Disease | 6 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Nephropathy

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benito S. Chan MD

29c. License number: D-20050

29d. Date signed (Month, Day, Year): 8/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BENITO S. CHAN 547-G Riverside Dr. Salisbury, MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8/13/01 0913

181-22-2424 Janet Molly

ET 4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended tiem # 10c & 10e, 8/14/2001, E.T, WCHD

# Certificate of Death

Reg. No. 2001 27014

MURRAY, REXUAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| REXUAL C. MURRAY | AUGUST 10, 2001 | 2:40 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BERLIN NURSING HOME | BERLIN | WORCESTER |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 222-14-3407 | 1[X] M 2[ ] F | 90 Yrs. | | | 1-4-1911 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WORCESTER | ~~WHALEYVILLE~~ Whaleyville | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| ~~9525 WHALEYVILLE ROAD~~ 9525 Whaleyville Road | 21872 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SELF EMPLOYED POULTRY FARMER | POULTRY FARMING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CURTIS W. MURRAY | ELIZABETH CAREY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JANICE POWELL/ DAUGHTER | RT#1 BOX CA5, FRANKFORD, DELAWARE. 19945 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | MARINER'S BETHEL CEMETERY | 8-13-01 | OCEAN VIEW, DELAWARE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Melson | MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST. FRANKFORD, DE. 19945 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarct Hours

Due to (or as a consequence of):

b. Coronary Artery Disease Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerosis Yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Depression

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[X] No | 1[ ] Yes 2[X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D02026 | 8-11-01 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ET 10

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27015

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CAROLINE E. MAIORANA
2. Date of Death: Month 8 Day 11 Year 2001
3. Time of Death: 0805
4a. Facility Name (If not institution, give street and number): 302 MARKET STREET
4b. City, Town, or Location of Death: POCOMOKE CITY
4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 217-22-9447
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 11-16-14
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 94TH STREET
10f. Zip Code: 21842
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): EZRA LITTLE
18. Mother's Name (First, Middle, Maiden Surname): CAROLINE GEIGER

19a. Informant's Name/Relationship (Type, Print): TERI C. PARKER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9618 MORRIS RD. BISHOPVILLE, MD 21853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY
Date: 8-12
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aortic Stenosis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. HYPERTENSION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steve Watkins MD
29c. License number: D 27993
29d. Date signed (Month, Day, Year): 8-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1001 Philadelphia Avenue Ocean City MD.

ET 3

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DEC 13 2001

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27016

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Esther Elizabeth Murray | Aug. | 9 | 2001 | 12:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 10012 Hayes Landing Rd. | Berlin | Worcester |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 221-16-0993 | 1☐ M 2☒ F | 78 Yrs. | | | | | Aug. 26, 1922 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Berlin | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10012 Hayes Landing Rd. | 21811 | US |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Sales | Shoe Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Fred Townsend | Agnes Bradford |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charlotte Smack | 10907 Adkins Rd., Berlin, Md. 21811 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Redmen's Cemetery | 8/11/2001 | Selbyville, Delaware |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kirk Burbage | The Burbage Funeral Home, 108 William st., Berlin, Md. 21811 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Adenocarcinoma of the lung | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D30619 | 8/9/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Abbott, M.D. 10445 Ocean City Blvd., Berlin, Md. 21811

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | B. Sparks |

DHMH 17 Rev 1/2001

ET 4

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27017

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Brother Thomas J. Nee, O.S.F.S.

2. Date of Death — Month: August Day: 8 Year: 2001

3. Time of Death: 1045 AM

4a. Facility Name (If not institution, give street and number): Annecy Hall

4b. City, Town, or Location of Death: Childs

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 221-60-2341

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 3, 1910

9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Childs

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1120 Blue Ball Road

10f. Zip Code: 21916

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Religious

17. Father's Name (First, Middle, Last): Patrick Nee

18. Mother's Name (First, Middle, Maiden Surname): Margaret Gilligan

19a. Intormant's Name/Relationship (Type, Print): Rev. Francis Hanlon, O.S.F.S.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2200 Kentmere Parkway, Wilmington, Delaware 19806

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Oblate Cemetery

Date: 8/11/01

20c. Location - City or Town, State: Childs, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

**Physician /Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Probable acute myocardial infarction — Immediate

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Dua to (or as a consequance ot):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy tindings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D44102

29d. Data signed (Month, Day, Year): 8/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Renzulli, M.D., 901 Warburton Road, Elkton, Maryland 21921

**State Registrar**

31. Date tiled (Month, Day, Year): AUG 0 9 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27018

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sophie Nowicki
2. Date of Death: Month August Day 6 Year 2001
3. Time of Death: 1948 M
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 185-09-1308
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25 1918
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 67 Elk Chase Drive
10f. Zip Code: 21921
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly line
16b. Kind of Business/Industry: Manufacturer

17. Father's Name (First, Middle, Last): John Zalewski
18. Mother's Name (First, Middle, Maiden Surname): Mary Zacher

19a. Informant's Name/Relationship (Type, Print): Joan M. Wright daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 Overlook Drive Wilmington DE

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gracelawn Memorial
Date: August 10, 2001
20c. Location - City or Town, State: New Castle DE

21. Signature of Funeral Service Licensee: Russell Gofus
22. Name and Address of Facility: Beeson Memorial Services 2053 Pulaski Hyw Newark De 19702

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Acute Respiratory Failure — Approximate Interval Between Onset and Death: 7days Appr
Due to (or as a consequence of):
b. Secondary to Staph pneumanitis — 7day Appr.
Due to (or as a consequence of):
c. Hypotension — 4days
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstonctive Pulmonary Disease
Chr Atrial fibrillation

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jayantilal K Patel MD
29c. License number: D 22307
29d. Date signed (Month, Day, Year): 08/07/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAYANTILAL K PATEL MD 1235 Singerly Ave, ELKTON, MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: Gene D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27019

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| MABEL A. NEAL | August 6 2001 | 1:26pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Doctors Hospital | Lanham | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-42-1696 | 1☐ M 2☒ F | 68 Yrs. | | | 02-28-33 | Washington D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince Georges | Glenarden | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7911 Piedmont Avenue | 20706 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Legal Secretary | Federal Gov't |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Fletcher Rosser, Sr. | Pearl B. Mack |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William Neal | 7911 Piedmont Avenue, Glenarden, MD 20706 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Ft. Lincoln Cemetery | 08-13-01 | Brentwood, MD |

21. Signature of Funeral Service Licensee ▶ Fred Strickland

22. Name and Address of Facility: Strickland Funeral Svc. P.A. 6500 Allentown Rd, Camp Springs, MD 20748

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MYOCARDIAL INFRACTION, | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Shobhit MD | D54675 | 8/7/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR SHOBHIT AKORA 575 MAIN STREET SUITE 351 LAUREL, MD 20707

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ Jeanne G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mabel Elaine Neal

CR

(10)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): REBA GERTRUDE NEWHOUSE

2. Date of Death: Month August Day 8 Year 2001

3. Time of Death: 8:28 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 180-20-2381

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 13, 1925

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10e. State: PA

10b. County: Westmoreland

10c. City, Town or Location: Derry

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 200 West Second Ave., Apt. 113

10f. Zip Code: 15627

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Foster J. Mardis

18. Mother's Name (First, Middle, Maiden Surname): Viola A. Sears

19a. Informant's Name/Relationship (Type, Print): Donna J. Kelly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.R. 1, Box 21, New Derry, PA 15671

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Blairsville Cemetery

Date: Aug. 13

20c. Location - City or Town, State: Blairsville, PA

21. Signature of Funeral Service Licensee: Douglas A Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure — weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischamic cardiomyopathy — years

Due to (or as a consequence of):

c. coronary artery disease — years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Liva birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: MD

29c. License number: D46081

29d. Date signed (Month, Day, Year): August 8, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): FRANK J COLLINS 1150A Professional court; HAGERSTOWN MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001

32. Registrar's Signature: Bonnie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

H283069

Newhouse Reba

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27021

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELLSWORTH GILBERT NEEDY
2. Date of Death (Month, Day, Year): AUGUST 14, 2001
3. Time of Death: 1215
4a. Facility Name (If not institution, give street and number): LINGANORE AVE. SIDEWALK AT CORNER OF MARSHALL ST. AND
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 217-28-7396
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 6, 1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: BOONSBORO
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 102 LAKIN AVENUE
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SERVICE MANAGER
16b. Kind of Business/Industry: GAS AND ELECTRIC CO.

17. Father's Name (First, Middle, Last): RUDOLPH NEEDY
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH GILBERT

19a. Informant's Name/Relationship (Type, Print): ANNA LOUISE NEEDY, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 LAKIN AVENUE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BOONSBORO CEMETERY | Date: AUG. 18 2001
20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Kelly A. Zimmerman
22. Name and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MASSIVE HEAD TRAUMA — Sudden
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) STREET

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): Aug 14 01
28b. Time of Injury: 11:30 AM
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: fell from ladder
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Sidewalk on Marshall & Linganore corner
28f. Location (Street and Number or Rural Route Number, City or Town, State): same as 28e

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0011266
29d. Date signed (Month, Day, Year): Aug 15 01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.N. Weeks 580 N. Potomac Ave Hagerstown Md

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27022

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANDY CLYDE POOLE
2. Date of Death Month Day Year: Aug 8th 2001
3. Time of Death: 13:00
4e. Facility Name (If not institution, give street and number): 1642 TRAPPE CHURCH RD
4b. City, Town, or Location of Death: DARLINGTON
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 161-20-2669
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/25/1925
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Darlington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1642 Trappe Church Road
10f. Zip Code: 21034
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Post Engineer
16b. Kind of Business/Industry: Civil Service
17. Father's Name (First, Middle, Last): George Thomas Poole
18. Mother's Name (First, Middle, Maiden Surname): Sarah Leila Murphy
19a. Informant's Name/Relationship (Type, Print): Wanda M. Griffith - Dau.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1638 Trappe Church Road, Darlington MD
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Nebo Cemetery
Date: 8/11
20c. Location - City or Town, State: Delta, PA
21. Signature of Funeral Service Licensee: Jeffrey P. Lovelace
22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASUVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME

29c. License number: DCME

29d. Date signed (Month, Day, Year): Aug 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GS. PRABHU M.D 728 BELAIR RD #134, BELAIR MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Alfred Perryman
CJ
01-4597-033

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 27023

UNPENDED 082901:ITEMS#23a,ptII,27,28a-f per ME G798 SS

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alfred B. Perryman
2. Data of Death: Month: August; Day: 11; Year: 2001
3. Time of Death: 03:19 A.M.
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 215-72-6782
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10-17-1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2302 Columbia Pl
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entrepreneur
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Willie W. Perryman Sr
18. Mother's Name (First, Middle, Maiden Surname): Madlyn Cottrell

19a. Informant's Name/Relationship (Type, Print): Madlyn Perryman/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 College Station Dr Upper Marlboro, MD 20774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 8-16-01
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: K. Wilson
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COCAINE INTOXICATION
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ASTHMA; PULMONARY THROMBOEMBOLI

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day, Year): 8-11-01
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2302 Columbia Pl., Landover, MD

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Caton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27024

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month Day Year) | 3. Time of Death |
|---|---|---|
| Jessie C. Page | July 31, 2001 | 8:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington Adventist Hospital | Takoma Park | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-42-1204 | 1☒ M 2☐ F | 76 Yrs. | | | Feb. 20, 1925 | Rock Hill, SC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| D.C. | N/A | Washington | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 812 Sheridan St. N.W. | 20011 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th | | Street Cleaner | Dept. of Public Works |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Pink Page | Amanda Miller |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Myrtle C. Page/Wife | 812 Sheridan St. NW Washington, DC 20011 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Harmony Memorial Park | 8-7-01 | Landover, MD. |

21. Signature of Funeral Service Licensee: J. P Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arrythmia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Hypokalemia | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery Disease, Chronic Obstructive Lung Disease, End Stage Renal Disease

23b. Did tobacco uas contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably X☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ NX |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D19609 | 7.31.01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, M.D. 10810 Darnestown Rd. #202 Gaithersburg, MD. 20878

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

(6)

**State Registrar**

31. Date filed (Month, Day, Year): AUG 06 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-4504-033
crn
Archie Postell

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 100101:ITEMS#23a,ptII,27,28a-f per ME G800 ss

# Certificate of Death

Reg. No: 2001 27025

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Archie Dee Postell

2. Date of Death — Month: August; Day: 08; Year: 2001

3. Time of Death: 1:20 A.M.

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-46-6061

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 15, 1936

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3201 Walters Lane #104

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Nathan Postell

18. Mother's Name (First, Middle, Maiden Surname): Ollie Bosier

19a. Informant's Name/Relationship (Type, Print): Cora B. Postell - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3201 Walters Lane, #104, Forestville, MD 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery

Date: 8/16/2001

20c. Location - City or Town, State: Wash., DC

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., DC 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERKALEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL DISEASE; DIABETES MELLITUS; HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 8-7-01

28b. Time of Injury: Unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject ingested mislabeled prescription medication

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State): Prince George's County, MD

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 08, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 16 2001

32. Registrar's Signature: Lynne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 27026

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Bhagwan | PraKash | | August 6 2001 | 905 AM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| The Johns Hopkins Hospital | Baltimore City | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-78-0128 | 1☒M 2☐F | 63 Yrs. | | | April 25,1938 | India |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Virginia | Fairfax | Springfield | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6435 Burwell St. | 22150 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Asian |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4+ | Broadcaster | Voice of America |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| R.K. Govil | Vidya Devi |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nitin Govil - Son | 6435 Burwell St. Springfield, VA. 22150 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | No. VA Crematory | August 7,2001 | Arlington, VA. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mary Holdben | Arlington Funeral Home. 3901 N. Fairfax Dr. Arlington, VA. 22203 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. RIGHT VENTRICULAR FAILURE | HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. PRIMARY GRAFT FAILURE | DAY |
| | Due to (or as a consequence of): c. ISCHEMIC CARDIOMYOPATHY | YEARS. |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the causa(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D57482 | 8/7/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID D. YUH, MD 600 North Wolfe Street Baltimore Md 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 0 8 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 27027

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Constance Louise Paul | August 12, 2001 | 5:15 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 212 Daycotah Avenue | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-46-1412 | 1☐ M 2☒ F | 54 Yrs. | | | April 27, 1947 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 212 Daycotah Avenue | 21740 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Supervisor | Food Service Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jesse Marion Southerly | Mary Elizabeth North |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Philip B. Paul, Husband | 212 Daycotah Avenue, Hagerstown, Maryland 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Rest Haven Cemetery | August 15, 2001 | Hagerstown, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| P. Steven Danfelt, Jr. P. Steven Danfelt, Jr. | Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, MD 21742 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Carcinoma of breast | 4 years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Frederick H Kass III MD | D23627 | August 13, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederick H Kass III MD 11110 Medical Campus Rd Hagerstown MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | Denise G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27028

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HOWARD LEE RUSSELL JR.

2. Date of Death (Month, Day, Year): August 10 2001

3. Time of Death: 20:44

4a. Facility Name *(If not Institution, give street and number)*: Union Hospital of Cecil County

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 176-07-3474

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov 27 1910

9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residence of Decedent

10a. State: MD

10b. County: Kent

10c. City, Town or Location: Galena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12391 Chesterville Rd.

10f. Zip Code: 21635

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: farmer

16b. Kind of Business/Industry: grain Farming

17. Father's Name *(First, Middle, Last)*: Howard Lee Russell Sr.

18. Mother's Name *(First, Middle, Meiden Surname)*: Minna Ellen Grier

19a. Informent's Name/Relationship *(Type, Print)*: Stephen L. Schaech

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: Box 235 Galena, MD 21635

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Spacify)*

20b. Placa of Disposition *(Neme of cemetery, crematory or other place)*: Kent Cremations | Date: 8/13/01

20c. Location - City or Town, Stata: Smyrna, DE

21. Signature of Funeral Service Licensee: [signature] M00510

22. Name and Address of Facility: Galena F.H. of Stephen L. Schaech 118 W. Cross St. Galena, MD 21635

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. cardiac arrest

Due to (or as a consequenca of): respiratory failure

Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last

b.

Due to (or as a consaquenca of): sepsis

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and manner as stated. 2 [ ] **Medicat Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] Paul M. Katz DO

29c. Licansa number: H0056426

29d. Data signad *(Month, Day, Year)*: 8/13/01

30. Name and eddress of person who completed cause of death (Item 29a) (Type, Print): Paul M. Katz DO 251 S. Bohemia Ave., Cecilton, MD 21913

**State Registrar**

31. Date filed *(Month, Dey, Year)*: AUG 13 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27029

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Peggy Ann Renner | August 13 2001 | 1954 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-32-6612 | 1☐M 2☒F | 66 Yrs. | | | June 12,1935 | West Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9829 Garis Shop Road | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unknown | unknown | homemaker | her own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Longerbeam | Elizabeth Turner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George B. Renner - husband | 9829 Garis Shop Rd., Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Cedar Lawn Mem. Park | 8-16-01 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee ▶ James R. Spicer

22. Name and Address of Facility MINNICH FUNERAL HOME
415 E.Wilson Blvd.,Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Subdural hematoma | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. end stage renal disease | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | B46111823 | August 14. 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YANPING YU. 12931 Oakhill Avenue. MD. 21742

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 15 2001 | James G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Peggy Ann Renner

01-4489-035
cm
Archie G. Riley

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27030

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Archie Garfield Riley JR.
2. Date of Death: Month August, Day 07, Year 2001
3. Time of Death: 6:00 A.M.
4a. Facility Name (If not institution, give street and number): Route 50 near Route 301
4b. City, Town, or Location of Death: Queenstown
4c. County of Death: Queen Anne's

**Funeral Director**

5. Social Security Number: 213-22-8682
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 14, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD. | 10b. County: Queen Anne's | 10c. City, Town or Location: Stevensville | 10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10a. Street and Number: 1739 Batts Neck Road | 10f. Zip Code: 21666 | 10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☑ Yes 2 ☐ No. If Yes, Give Year or Dates: 3/10/1946 - 6/24/1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Entrepreneur

17. Father's Name (First, Middle, Last): Archie Garfield Riley SR.
18. Mother's Name (First, Middle, Maiden Surname): Delma Earl

19a. Informant's Name/Relationship (Type, Print): Patricia Demby
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 948 Dulin Creek Road Centreville Maryland

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Veterans Cemetery | Date: 8/17/2001
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 8/7/01
28b. Time of Injury: 0600AM
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: Driver of Motor Vehicle Hit By Truck
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Route 50 Queenstown, Maryland

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 08, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27031

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month Day Year) | 3. Time of Death |
|---|---|---|
| Dorothy Eleanor Sawyer | AUGUST 9, 2001 | 10:57 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SAINT JOSEPH MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 505-18-1340 | 1☐ M 2☒ F | 81 Yrs. | | | Dec. 11, 1919 | Wyoming |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Joppa | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 127 Ravenswood Court | 21085 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yas, Give Yaar or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elamantary/Sacondary (0-12) | Collega (1-4or 5+) | | |
| | 3 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Calvert James Acheson | Winifred Irene Boat |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leonard E. Sawyer/Son | 2016 Bulls Sawmill Road, Freeland, MD 21053 |

| 20a. Method of Disposition | 20b. Placa of Disposition (Name of cemetery, crematory or other placa) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Trinity Lutheran Cem. | 8/11/01 | Joppa, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Heath A. Keagle | McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter tha disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| Immediata Causa (Final disaasa or condition resulting in death) | a. SEPSIS SECONDARY TO | 25 DAYS |
| Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last | b. Due to (or as a consequenca of): LEAKING COLORECTAL ANASTOMOSIS | |
| | c. Due to (or as a consequence of): STATUS POST ANTERIOR RESECTION | |
| | d. Due to (or as a consequence of): OF RECTAL CARCINOMA WITH LIVER METASTASIS | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery (Month Day Year) |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pragnant at time of daath 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Ware autopsy findings available prior to compilation of cause of death? |
|---|---|---|
| 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yas 2☐ No |

| 25. Was casa raferred to medical examinar? | 26. Placa of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Mannar of Death | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined | | M | 1☐ Yas 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurrad at tha time, data and placa, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, date and place, and dua to tha cause(s) and manner stated.

| 29b. Signatura and title of cartifier | 29c. Licanse numbar | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| Pemy Chhim M.D. | D 26954 | 08/09/01 |

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)
PEMY CHHIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | Benna G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

ADH
AUGUST SCHROEDER
01-4559-015

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27032

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): AUGUST ADAM SCHROEDER
2. Date of Death: Month AUGUST Day 9, Year 2001
3. Time of Death: 1055 AM
4a. Facility Name (If not institution, give street and number): 55½ RED HILL ROAD
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 221-24-8337
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JUNE 23, 1939
9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MD. | 10b. County: CECIL | 10c. City, Town or Location: ELKTON | 10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 55½ RED HILL ROAD | 10f. Zip Code: 21921 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GENERAL LABORER
16b. Kind of Business/Industry: LABOR

17. Father's Name (First, Middle, Last): HARRY SCHROEDER
18. Mother's Name (First, Middle, Maiden Surname): CHARLOTTE HARRISON

19a. Informant's Name/Relationship (Type, Print): WILLIAM SCHROEDER - BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 142 OLD LANDING ROAD REHOBETH DEL. 19971

20a. Method of Disposition: 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. FERRIS INC. | Date: 8/14/01
20c. Location - City or Town, State: W. Chester Pa.

21. Signature of Funeral Service Licensee: ▶ Edward McKeown
22. Name and Address of Facility: SEE FUNERAL HOME 259 E. MAIN ST. ELKTON, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease complicated by Environmental Hyperthermia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Chronic Alcoholism

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (If) (Month, Day, Year): 8/9/01
28b. Time of Injury (If): 10:00 A M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Exposure to high environmental temperatures
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 55½ RED HILL ROAD ELKTON, MD

29a. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ J. M. T.
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: ▶ Jeanne P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27033

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Homer Cleveland Saunders
2. Date of Death (Month, Day, Year): August 2, 2001
3. Time of Death: 1:59 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-03-7883
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 28, 1903
9. Birthplace (State or Foreign Country): Criglersville, VA
Usual Residence of Decedent
10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 315 Emerson St. NW
10f. Zip Code: 20011
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hotel Manager
16b. Kind of Business/Industry: Army/Navy Club
17. Father's Name (First, Middle, Last): William Saunders
18. Mother's Name (First, Middle, Maiden Surname): Lucy Jessie
19a. Informant's Name/Relationship (Type, Print): Myra Weston/Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 315 Emerson St. NW Washington, DC 20011
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery
Date: 8-8-01
20c. Location - City or Town, State: Suitland, MD.
21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. INANITION — MONTHS

Due to (or as a consequence of):
b. ALZHEIMERS DEMENTIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PROSTATE CANCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D42403
29d. Date signed (Month, Day, Year): 8/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 IRVING STREET NW WASHINGTON DC 20010

**State Registrar**

31. Date filed (Month, Day, Year): AUG 06 2001
32. Registrar's Signature: Sandra G. Spratt

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

(4)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27034

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Snipes
2. Date of Death Month / Day / Year: August 1, 2001
3. Time of Death: 11:20 PM
4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 579-30-4142
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 17, 1917
9. Birthplace *(State or Foreign Country)*: Pittsboro, NC

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1136 Buchanan St. N.W.
10f. Zip Code: 20011
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Henry Snipes
18. Mother's Name *(First, Middle, Maiden Surname)*: Violet Brooks

19a. Informant's Name/Relationship *(Type, Print)*: Thomasine Cox/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1136 Buchanan St. NW Washington, DC 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Lincoln Cemetery
Date: 8-8-01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th ST. N.W. Washington, D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR Disease Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia - End Stage; Decubitus Ulcers - Chronic

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Ward MD
29c. License number: D01852
29d. Date signed *(Month, Day, Year)*: August 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A DeVore MD 4200 Queensbury Rd Hyattsville MD 20781

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 06 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH t6 Rev 6/95

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27035

Amend # 20b. Per FH 8-8-01 cr

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HORACE A. SCOTT | Aug. 2, 2001 | 10:45P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1896 Addison Rd. South | Forestville | P.G. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 230-44-1809 | 1 [X] M 2 [ ] F | 65 Yrs. | | | 6/13/36 | VA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | P.G. | Forestville | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1896 Addison Rd. South | | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes [X] No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Postal Clerk | U.S. Post Office |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel Piatt | Betsy Harrison |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Scott/wife | 1896 Addison Rd. S. Forestville, Md.20747 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Washington Nat. Cem | 8/8/01 | Suitland,MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Reny Hodges | Hodges and Edwards 3910 Silver Hill Rd. Suitland,Md.20746 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung Cancer | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. COPD | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29e. Certifier (Check only one)
1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Karenga Lemmons MD. | D31711 MD | 8/3/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karenga R. Lemmons MD. 6104 Old Branch Ave Camp Springs

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 07 2001 | Gerdine G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

(12)

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27036

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Nava | Sarver | August 3, 2001 | 6:05P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Suburban Hospital | Bethesda | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 127-44-4140 | 1☐M 2☒F | 50 Yrs. | | | Feb.28,1951 | Israel |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Potomac | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8122 Tuckerman Lane | 20854 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5 | Scientist | National Institute of Health |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Yehudah Sarver | Hemdah Julius |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Hanna Z. Weissberger-Friend | 19720 Framingham Drive Gaithersburg, Maryland20879 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Garden of Remembrance | 8/8/2001 | Clarksburg, Maryland |

21. Signature of Funeral Service Licensee: ▶ Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. respiratory failure | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. myasthenia gravis | years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D33293 | August 4, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick P. Smith, M.D. 5401 Wisconsin Ave., N.W. Washington, D.C. 20015

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 08 2001 | ▶ |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dr. Nava Sarver 8/3/01 6:05pm

(40)

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a perPHYG798 8/28/01 EW

# Certificate of Death

2001 27037
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES W. SHICK
2. Date of Death: Month AUGUST Day 13 Year 2001
3. Time of Death: 0945 AM
4a. Facility Name (If not institution, give street and number): UNION HOSPITAL
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 207-22-2899
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 4, 1929
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: MD. | 10b. County: CECIL | 10c. City, Town or Location: ELKTON | 10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 10 KENNEDY BLVD. | 10f. Zip Code: 21921 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAIL CARRIER
16b. Kind of Business/Industry: POSTAL SERVICE

17. Father's Name (First, Middle, Last): Forest E. SHICK
18. Mother's Name (First, Middle, Maiden Surname): SARAH GRAHAM

19a. Informant's Name/Relationship (Type, Print): MARIAN A. SHICK - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #10 KENNEDY BLVD ELKTON, MD 21921

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RA FERRIS INC. | Date: 8/17/01
20c. Location - City or Town, State: W. Chester PA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: GEE FUNERAL HOME 259 E. MAIN ST. ELKTON, MD 21921

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Massive Hemoptysis — ~~Plus DNR~~
Due to (or as a consequence of):
b. Laryngeal Cancer ~~S/P Radiation Tx~~
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Lung Cancer
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Karen L. Canter MD
29c. License number: D57520
29d. Date signed (Month, Day, Year): 08/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen Canter MD 322 E. Cecil Ave. North East, MD 21901

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27038

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Harry Junior STONEBERGER | August 9 2001 | 1:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-12-0753 | 1☒M 2☐F | 78 Yrs. | | | Feb.14,1923 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 26 South Mulberry Street | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 3 | 0 | construction worker | construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry W. Stoneberger | Della Alishire |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wanda L. Stoneberger - wife | 26 S. Mulberry St., Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Boonsboro Cemetery | 8-11-01 | Boonsboro, Maryland |

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Aspiration Pneumonia | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AFib
COPD CAD
Htn

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 50362

29d. Date signed (Month, Day, Yeer): August 10, 2001

30. Name and address of peleon who completed cause of death (Item 23a) (Type, Print): Dr. Cantore 22911 Jefferson Blvd. Smithsburg, md. 21783

**State Registrar**

31. Date filed (Month, Day, Year): AUG 1 0 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Stoneberger, Harry Junior

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27039

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Henry Fletcher Stouffer
2. Date of Death Month Day Year: August 8, 2001
3. Time of Death: 1213 P M
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 164-30-4898
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 9, 1936
9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: Penna.
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8796 Willowdale Rd.
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Contractor
16b. Kind of Business/Industry: Home Construction

17. Father's Name (First, Middle, Last): J. Hoke Stouffer
18. Mother's Name (First, Middle, Maiden Surname): C. Elizabeth Brake

19a. Informant's Name/Relationship (Type, Print): Jean M. Stouffer/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8796 Willowdale Rd. Greencastle, Pa. 17225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 8/11/01
20c. Location - City or Town, State: Greencastle, Pa.

21. Signature of Funeral Service Licensee: ▶ H. Martin Zimmerman Jr.
22. Name and Address of Facility: Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — Approximate Interval: 10 years.
Due to (or es a consequenca of):
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequenca of):
d.

IF FEMALE.
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Othar (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: ▶ L. Rao, MD
29c. License number: D 51282
29d. Date signed (Month, Day, Year): 8/9/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Rao 13630 Molly Pitcher Hwy. Greencastle, Pa. 17225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27040

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARION PARIS SUTPHIN

2. Date of Death Month / Day / Year: Aug. 18 2001

3. Time of Death: 12:05 AM

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 218-12-9927

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 6, 1924

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: Old Aldinia Road

10f. Zip Code: 20678

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Auto

17. Father's Name *(First, Middle, Last)*: Charlie Sutphin

18. Mother's Name *(First, Middle, Maiden Surname)*: Ola Lambert

19a. Informant's Name/Relationship *(Type, Print)*: Gary Sutphin

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 114 Hickory Lane, Meadows of Dan, VA 24120

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Alderman Cemetery

Date: 08/20/01

20c. Location - City or Town, State: Willis, VA

21. Signature of Funeral Service Licensee: Carlin J Maberry

22. Name and Address of Facility: Maberry Funeral Home, Inc. 367 South Locust Street, Floyd, VA 24091

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D33123

29d. Date signed *(Month, Day, Year)*: 8-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Lowenthal Calvert Memorial Hosp. Prince Frederick, Md

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27041

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bertha Thompson

2. Date of Death: Month August Day 11 Year 2001

3. Time of Death: 5:20 am

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 232-42-4699

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 13, 1909

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 139 Plum Creek Road

10f. Zip Code: 21901

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Practial Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): William Williams

18. Mother's Name (First, Middle, Maiden Surname): Clara Shaw

19a. Informant's Name/Relationship (Type, Print): Eleanor Margaret Tyson-Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 139 Plum Creek Road North East, Maryland 21901

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): North East Methodist

Date: 2001 August 14

20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Crouch Funeral Home 127 South Main Street North East, Maryland 21901

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

rgw

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. congestive cardiomyopathy — Years

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Coronary artery disease

Due to (or es a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31712

29d. Date signed (Month, Day, Year): 8/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK III MD 2196 Belair Rd Aberdeen, MD 21001

Thompson, BERTHA

6

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: [signature] S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27042

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Toby Temoney
2. Date of Death: Month August Day 1 Year 2001
3. Time of Death: 1:10 P.M.
4a. Facility Name (If not institution, give street and number): Mariner Health of Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-18-6998
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): January 24, 1912
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 901 Arcola Avenue Mariner Health of Silver Spring
10f. Zip Code: 20902
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Aug.1942 Oct.1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Taxi Cab Driver
16b. Kind of Business/Industry: Taxi Cab Company

17. Father's Name (First, Middle, Last): Leonard Temoney
18. Mother's Name (First, Middle, Maiden Surname): Anna Lee (unknown)

19a. Informant's Name/Relationship (Type, Print): John Vaughn (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9906 Hedin Drive; Silver Spring,Maryland 20903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: Aug. 7,2001
20c. Location - City or Town, State: Brentwood,Maryland

21. Signature of Funeral Service Licensee: Kenneth Chism
22. Name and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ALZHEIMER'S DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barry Rosenbaum
29c. License number: DO 9834
29d. Date signed (Month, Day, Year): August 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barry N. Rosenbaum, M.D.; 3720 Farragut Avenue; Kensington, Maryland 20895

**State Registrar**

31. Date filed (Month, Dey, Year): AUG 06 2001
32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

01-4422-033
B.K.S
NEGASSI K. TINSAE

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27043

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: NEGASSI K. TINSAE
2. Date of Death Month, Day, Year: AUG. 4, 2001
3. Time of Death: 0534 AM
4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 151-80-0070
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 38 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-08-62
9. Birthplace *(State or Foreign Country)*: Eritrea

Usual Residance of Decedent

10a. State: D.C.
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 1439 "T" Street, N. W. Apt. 104
10f. Zip Code: 20009
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Cashier
16b. Kind of Business/Industry: Gasoline Station

17. Father's Name *(First, Middle, Last)*: Kifleyesus Tinsae
18. Mother's Name *(First, Middle, Maiden Surneme)*: Letekidan Taffla

19a. Informant's Name/Relationship *(Type, Print)*: Yohannes Tinsae (Brother)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 842 Continental Ct. Apt. 4 Vadalia, Ohio 45377

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cametery, crematory or other place)*: Family Cemetery — Date: 08-13-01
20c. Location - City or Town, State: Asmara, Eritrea

21. Signature of Funeral Service Licensee: Bacon Funeral Home, Inc.
22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D./ C. 20010

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ruptured aortic Aneurysm
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or es a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceusa of death? 1 [X] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Plece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other *(Specify)*
27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E
29d. Data signed *(Month, Day, Year)*: AUG. 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Dey, Year)*: AUG 08 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

(5)

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27044

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Javanni Maurice Virgil
2. Date of Death: Month 07 Day 31 Year 2001
3. Time of Death: 3:15am
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months | Days 1 | If Under 24 Hrs.: Hours | Min.
8. Date of Birth (Month, Day, Year): July 30, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Prince Georges
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1005 Summerglen Court
10f. Zip Code: 20721
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) N/A; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A
17. Father's Name (First, Middle, Last): Marcel Virgil
18. Mother's Name (First, Middle, Maiden Surname): Pamela Denise McCoy
19a. Informant's Name/Relationship (Type, Print): Pamela D. Virgil / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 Summerglen Court, Mitchellville, MD 20721
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Cemetery
Date: 8-11-01
20c. Location - City or Town, State: Landover, MD
21. Signature of Funeral Service Licensee: K. W...
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Rd., Landover, MD 20785

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NEONATAL SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. CHORIOAMNIONITIS

Due to (or as a consequence of):
c. PREMATURE PROLONGED RUPTURE OF MEMBRANES

Due to (or as a consequence of):
d. EXTREME PREMATURITY

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Antoine K. Fomufod, M.D.
29c. License number: D 16239
29d. Date signed (Month, Day, Year): 7/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTOINE K. FOMUFOD, M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MD. 20785

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Amend Item#14** Per FH 8-14-2001 HCHD LM

# Certificate of Death

Reg. No. 2001 27045

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lawrence Marshall Whittington | August 6, 2001 | 11:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2128 Thomas Run Road | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex 1☒M 2☐F | 7. Age (In yrs. last birthday) Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-24-9479 | | 92 | | | Feb. 20, 1909 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Bel Air | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2128 Thomas Run Road | 21014 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: ~~White~~ Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 7 | | Stock Clerk | Furniture Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alfred (u/k) Whittington | Ella (u/k) Cascoe |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Vanessa A. Peaker / Niece | 1303 Clover Valley Way, Unit E, Edgewood, MD 21040 |

| 20a. Method of Disposition 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| | Clarks Chapel Cem. | 8-11-01 | Bel Air, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular disease | ten years |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mark Wild | d35522 | August 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARK WILD 2 NORTH AVENUE BEL AIR MARYLAND 21014

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ Penny G Sparks |

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27046

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Wilmer R. Woodhull | August 7 2001 | 23:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARFORD MEMORIAL HOSPITAL | HAVRE DE GRACE, MARYLAND | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 202-03-3976 | 1☒M 2☐F | 82 Yrs. | | | JULY 27, 1919 | PENNSYLVANIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | CECIL | CHARLESTOWN | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 725 WATER STREET, P.O.BOX 324 | 21914 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1941-43 | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | TWO YEARS | PROJECT MANAGER | R. C. A. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILMER WOODHULL | CATHERINE McELROY WOODHULL |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALICE WOODHULL | 725 WATER ST., P.O.BOX 324, CHARLESTOWN, MARYLAND |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CHARLESTOWN CEMETERY | AUG. 11, 2001 | CHARLESTOWN, MARYLAND |

21. Signature of Funeral Service Licensee: Lee A. Patterson Sr.

22. Name and Address of Facility: LEE A. PATTERSON & SON FUNERAL HOME, P. A. P.O.BOX 188, PERRYVILLE, MARYLAND. 21903

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Hepatic Encephalopathy | 2 days |
| Due to (or as a consequence of): | b. Gastrointestinal Hemorrhage | 4 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Gastric varices | 4 Months |
| Due to (or as a consequence of): | d. Liver cirrhosis | 5 years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C virus
Coagulopathy
Severe Malnutrition

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and pleca, and due to tha causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D53568 | August 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey A Thompson MD 3003 Floribunda Ct Fallston MD 21047

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | Barbara D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27047

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| West Wall | August 3, 2001 | 1508 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 578-24-6356 | 1☒M 2☐F | 80 Yrs. | | | May 5, 1921 | Rockingham, NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Mitchellville | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11500 Tommy Court | 20721 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 years | | Clerk | Governmnet |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Gus Wall | Daisy Ellerbe |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Benkey Wall - Brother | 3112 N. Napa Street Philadelphia, PA 19132 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Arlington Nat'l Cemetery | August 21, 2001 | Arlington, Virginia |

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. Wash. D.C. 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Respiratory failure | days |
| Due to (or as a consequence of): b. | Pneumonia | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. | Myocardial infarction | days |
| Due to (or as a consequence of): d. | | |

IF FEMALE:

| 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Hung Davis MD | D53111 | 8/4/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HUNG DAVIS ANNE ARUNDEL MED. CTR. 64 FRANKLIN ST. ANNAP., MD. 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 08 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27048

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Beulah Jett Watkins

2. Date of Death — Month: August Day: 5, Year: 2001

3. Time of Death: 9:15 P.M.

4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center of Hyattsville

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 579-14-2921

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: November 28, 1907

9. Birthplace *(State or Foraign Country)*: Washington,D.C.

Usuei Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 6500 Riggs Road Heartland Health Care Center of Hyattsville

10f. Zip Coda: 20783

10g. Citizan of What Country?: United States

11. Marital Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)* — Elementary/Secondery (0-12): 9 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Elevator Operator

16b. Kind of Businass/Industry: unk.

17. Father's Nama *(First, Middle, Last)*: Malachi Jett

18. Mothar's Name *(First, Middle, Maiden Surname)*: Mattie Jeffiers

19a. Informant's Name/Raiationship *(Type, Print)*: Matilda Ethel Jett Brown(Niece)

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 6424 North Capitol Street,N.W.;Washington,D.C.20011

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nema of cematary, cramatory or othar place)*: Lincoln Memorial Cemetery — Data: August 10,2001

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funaral Sarvice Licansee: Kenneth Chem

22. Name and Addrass of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy STreet,N.W.;Washington,D.C. 20011

**Physician /Medical Examiner**

23e. Part1. Enter the disaesa, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory errest, shock, or heart feiiure. List only one cause on eech line. — Approximate Interval Batween Onsat and Death

Immedieta Ceusa (Final disaasa or condition resulting in death): a. ARTHEROSCLEROTIC CARDIOVASCULAR Disease years

Due to (or es a consequenca of):

Sequentially list conditions, if any, laading to immedieta causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last:

b. Dua to (or as a consequenca ot):

c. Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Wes casa ratarred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Deeth *(Check only ona)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, tactory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, deeth occurred at tha tima, data and piaca, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and piaca, and dua to the cause(s) and mannar statad.

29b. Signeture and titla of certifiar: Paul A. DeVore, M.D.

29c. Licansa number: D01852

29d. Date signed *(Month, Day, Year)*: August 6 , 2001

30. Name and addrass of person who completed causa of daath (Item 23e) (Type, Print): Paul A. DeVore, M.D.; 4203 Queensbury Road; Hyattsville, Maryland 20781

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 07 2001

32. Registrar's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27049

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| James Addison Whitaker | August 07 2001 | 2:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Health Care | Baltimore, Maryland 21229 | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 242-18-9385 | 1 X M 2 F | 88 Yrs. | | | Oct. 4, 1912 | North Carolina |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| N.C. | Edgecombe | Rocky Mount | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 144 Whitaker Road | 27801 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: African American |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Custodian | Maintenance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Julius Edward Whitaker | Mary Edwards |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sophia Thompson/Daughter | 6632-23rd. Ave., Hyattsville, MD 20782 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Northeastern Cem. | 08-11-01 | Rocky Mount, NC |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Bennie L. Lee III | Stokes Mortuary 207 Albemarle Ave., Rocky Mount, NC |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 24 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Lung Carcinoma | Unknown |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 ✓ Unknown | 1 Yes 2 ✓ No | 1 Yes 2 ✓ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 ✓ No | Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Leila Kump, M.D. | P 14444 | Aug 7, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leila Kump 900 Caton Ave Baltimore 21229 MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ Bernice G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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**NAME** Whitaker, James

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27050

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| ELIZABETH DENISE WILLIAMS | | | August | 5 | 2001 | 9:35 PM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | |
| DOCTORS COMMUNITY HOSPITAL | LANHAM | | PRINCE GEORGES | | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-82-4174 | 1☐M 2☒F | 38 Yrs. | | | | | Oct. 29, 1962 | Washington, DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | Glenarden | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1409 8th Street | 20706 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 1yr | School Crossing Guard | DC Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Williams Sr. | Mary Nobles |

| 19a. Informent's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Lisa Williams / Sister | 1409 8th Street Glenarden, Maryland 20706 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Harmony Memorial Park | 08-11-2001 | Landover, Maryland |

21. Signature of Funeral Service Licensee: Maurice L. Braxton

22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MARYLAND 20746

**To Be Completed by Funeral Director**

Elizabeth Denise Williams

1409 8th Street, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode ot dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. Pulmonary Emolesin

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. CA of Colon

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE.

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Daath (Check only one)

Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Mennet of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | MDD 44276 | August 5, 2001 |

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Sidney Z. Lawrence, MD 8118 Good Luck Rd. Lanham, MD 20706

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27051

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Yaar | 3. Time of Death |
|---|---|---|
| Robert Martin Weller | August 12, 2001 | 0850 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Daath |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 214-10-4594 | 1 [X] M 2 [ ] F | 89 Yrs. | | | | | 12/24/11 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MD | Washington | Hagerstown | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 619 Chestnut St. | 21740 | USA |

| 11. Maritat Status | 12. Wes Decedent Ever in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Electrician | General Contracting |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surnama) |
|---|---|
| Martin Luther Weller | Bertha Stotler |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Numbar or Rurel Routa Number, City or Town, State, Zip Code) |
|---|---|
| Mary Jane Weller Wife | 619 Chestnut St., hagerstown, MD 21740 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Nama of cematery, cremetory or other place) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removat from State 4 [ ] Donation 5 [ ] Other (Specify) | Rest haven Cemetery | 8/15/01 | Hagerstown, MD |

| 21. Signeture of Funeral Service Licensee | 22. Nama and Address of Feciliity |
|---|---|
| Gerald N. Minnich | Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications thet ceused tha deeth. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Batwean Onsat and Daath |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | 4W |
| Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as e consequence of): b. CONGESTIVE HEART FAILURE | 5Y |
| | Due to (or as e consequence of): c. HYPERTENSION | 25Y |
| | Due to (or as e consequence of): d. HYPOTHYROIDISM | 25Y |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of dalivary Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of daeth 5 [ ] Othar (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

ATRIAL FIBRILLATION

DEGENERATIVE JOINT DISEASE

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an eutopsy performed? | 24b. Were eutopsy findings availabte prior to compiation of causa of deeth? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yas 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yaar) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | | 1 [ ] Yas 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)

1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and dua to the causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Dey, Yaer) |
|---|---|---|
| [signature] | 052323 | 8/12/01 |

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

Dr. Warren 19414-C Leitersburg Pike Hag. md. 21742

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 15 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with this Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

August 13, 2001

Weller, Robert

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27052

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia Lynn Williams

2. Date of Death: Month Aug. Day 10 Year 2001

3. Time of Death: 7:57A M

4a. Facility Name (If not institution, give street and number): III N. E. Railroad Ave.,

4b. City, Town, or Location of Death: Hebron

4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 213-78-1935

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yaar): Aug. 8, 1962

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Hebron

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: III N.E. Railroad Ave.

10f. Zip Code: 21850

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Robert John Logan

18. Mother's Name (First, Middle, Maidan Surname): Julia Marie Parsons

19a. Informant's Name/Relationship (Type, Print): Conrad Williams

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): III N.E. Railroad Ave., Hebron, Md. 21830

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or othar place): Cape Henlopen Crematory

Date: Aug. 13, 2001

20c. Location - City or Town, Stata: Frankford, Delaware

21. Signature of Funeral Service Licensee: [signature] M00701

22. Name and Address of Facility: The Burbage Funeral Home 108 William St., Berlin, Md. 21811

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Osteosarcoma — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fatel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Chack only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D30690

29d. Date signed (Month, Day, Year): Aug. 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. MARTIN M.D. 145 E. Carroll St., Salisbury, MD.

DH. 6.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27053

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William L. Younger
2. Date of Death: Month August Day 4, Year 2001
3. Time of Death: 1:15 pm
4a. Facility Name (If not institution, give street and number): Fox Chase Rehabilitation Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-38-5602
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 12, 1930
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 11700 Old Columbia Pike Apt 1713
10f. Zip Code: 20904
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Procurement Specialist
16b. Kind of Business/Industry: Federal Gov't

17. Father's Name (First, Middle, Last): George A. Younger
18. Mother's Name (First, Middle, Maiden Surname): Esther McLendon

19a. Informent's Name/Relationship (Type, Print): Marguerite Smith/ sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1735 Massachusetts Ave. SE Washington, DC 20003

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veteran's
Date: 8/10/01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Richard Thompson II MO1285
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic carcinoma — weeks.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D50678
29d. Date signed (Month, Day, Year): August 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajeev Batra, M.D. 11120 New Hamshire Ave. suite 309 Silver Spring, MD 29094

**State Registrar**

31. Date filed (Month, Day, Year): AUG 07 2001
32. Registrar's Signature: Geneva B. Scott

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27054

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOAN C. ANDERSON
2. Date of Death: Month: August; Day: 19; Year: 2001
3. Time of Death: 4:45pm
4a. Facility Name (If not Institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-46-1364
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-31-1945
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1624 DIVISION STREET
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DEPUTY CLERK
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): SILAS ANDERSON
18. Mother's Name (First, Middle, Maiden Surname): RENA WATKINS

19a. Informant's Name/Relationship (Type, Print): EMMA M. ANDERSON HUDSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3551 SEA PINES CIR., RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL; Date: 8-25-01
20c. Location - City or Town, State: ELKRIDGE, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory Failure
Due to (or as a consequence of):
b. Breast Cancer with Metastatic Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: P14574
29d. Date signed (Month, Day, Year): 08-19-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Woodward Dixon M.D. C/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

JOAN Anderson

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27055

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY BROWN

2. Date of Death: Month AUGUST Day 12 Year 2001

3. Time of Death: 9 11 AM

4a. Facility Name (If not institution, give street and number): BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-24-2847

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): MAR. 9, 1929

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 22 S. ATHOL AVENUE

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 3rd

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

18b. Kind of Business/Industry: Unk

17. Father's Name (First, Middle, Last): Unk

18. Mother's Name (First, Middle, Maiden Surname): Unk

19a. Informant's Name/Relationship (Type, Print): SHEILA WILLIAMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 S. Athol Ave Balto. Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem

Date: 8/21/2001

20c. Location - City or Town, State: Balto. Md

21. Signature of Funeral Service Licensee: Flora Adams Jones

22. Name and Address of Facility: MITCHELL W. JONES JR F.H. P.A. 4101 Edmondson Ave. Balto. Md 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. 30% BODY SURFACE AREA BURN — 4 MONTHS

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

DECLARATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ___ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL VASCULAR ACCIDENT, HYPOALBUMINEMIA, CORONARY ARTERY DISEASE, RESPIRATORY FAILURE, VENTILATOR DEPENDENCE, CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): APRIL 23 2001

28b. Time of Injury: 1028 AM

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: SUBJECT DROPPED LIT CIGARETTE INTO LAP

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NURSING HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 22 SOUTH ATHOL AVE. BALTIMORE, MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: WRG MD

29c. License number: D043 85

29d. Date signed (Month, Day, Year): 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM GREENOUGH, M.D. 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: B. Sparks

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27056

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Barbara C. Buelage
2. Date of Death Month Day Year: Aug 23 2001
3. Time of Death: 7:10 AM
4a. Facility Name (If not institution, give street and number): Carroll County Gen. Hos
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 213-28-1981
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 22, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baldwin
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6223 Windy Ridge Rd.
10f. Zip Code: 21013
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Hutschenreuther
18. Mother's Name (First, Middle, Maiden Surname): Alma Blie

19a. Informant's Name/Reletionship (Type, Print): John E. Buelage, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6223 Windy Ridge Rd. Baldwin, Md 21013

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Ceme Date: Aug 27 2001
20c. Location - City or Town, State: Parkville, Md

21. Signature of Funeral Service Licensee: Kenta S Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Heart Disease — Approximate Interval Between Onset and Death: 1mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): ASCVD — 25yr
c. Due to (or as a consequence of): advanced age — 93y
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 8-23-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster Md 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 25a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27057

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Julia Badalian

2. Date of Death: Month August, Day 15, Year 2001

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 047-10-5674

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sept 1, 1910

9. Birthplace (State or Foreign Country): Massachussetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 715 Maiden Choice Lane Parkview 619

10f. Zip Code: 21228

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian

16b. Kind of Business/Industry: Library

17. Father's Nama (First, Middle, Last): Michael P. Moriarty

18. Mother's Nama (First, Middle, Maiden Surname): Mary O'Connor

19a. Informant's Name/Reletionship (Type, Print): Thomas J. Moriarty - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane, 619 HR, Catonsville, MD 21228

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Cemetery

Data: 8/20/01

20c. Location - City or Town, Stete: W. Hartford, CT

21. Signature of Funaral Service Licensee: ▶ Ann Y. Zink

22. Nama and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cerebral vascular accident — days

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure — days

Dua to (or as a consequence of):

c. Acute myocardial infarction — days

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signatura and title of certifier: ▶ Myla M Carpenter MD

29c. License number: D 30989

29d. Date signed (Month, Day, Year): August 15 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 2 4 2001

32. Registrer's Signature: ▶ Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Badalian, Julia Aug 15 2001 1PM

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #5 PER FH G801 11/26/01 JH

# Certificate of Death

Reg. No. 2001 27058

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DELORES D. BAPTISTE

2. Date of Death (Month, Day, Year): August 23, 2001

3. Time of Death: 12:20 AM

4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 217-24-~~1625~~ 1623

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 6, 1931

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 633 N. AUGUSTA AVENUE

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHILDCARE PROVIDER

16b. Kind of Business/Industry: DAYCARE

17. Father's Name (First, Middle, Last): ELMER LAMBSON

18. Mother's Name (First, Middle, Maiden Surname): LOUISE LAMBSON

19a. Informant's Name/Relationship (Type, Print): ARNETT DUCKETT (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3624 EITEMILLER ROAD BALTIMORE, MD 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST CEM.

Date: 8/28/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cerebral vascular Accident — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Congestive Heart failure

Hypertension.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edana Mann, M.D.

29c. License number: D0076092

29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edana Mann 900 Caton Avenue Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

& Baptist, Delores

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27059

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Viola Billheimer

2. Date of Death — Month: August Day: 21 Year: 2001

3. Time of Death: 6:06 PM

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-34-7016

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Nov. 9, 1931

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3710 1/2 Elm Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Henley

19a. Informant's Name/Relationship *(Type, Print)*: Robert Billheimer Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3710 1/2 Elm Avenue Baltimore, MD 21211

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 8/23

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Tracy H Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery — Month: Day: Year:

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Morbid Obesity

Seizure Disorder

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anil Uberoi MD

29c. License number: D26748

29d. Date signed *(Month, Day, Year)*: 8/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANIL UBEROI 4419, FALLS RD BALTO MD 21211

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27060

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| EMANUEL | BROWDY | AUGUST 21 2001 | 11:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNION MEMORIAL HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-32-1707 | 1 X M 2 F | 88 Yrs. | | | SEPT 2, 1912 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3216 NORTHBROOK RD | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | PHARMACIST | PHARMACEUTICAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| OSCAR BROWDY | IDA KRAMER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MS DONNA GOLDMAN (DAU) | 2215 WOODBOX LA., APT. A BALTO., MD 21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | SHAAREI TFILOH | 8/23/2001 | BALTIMORE, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 48 HRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. PNEUMONIA | 48 HRS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF CHOLELITHIASIS

DVT C. DIFF COLITIS

MI

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 Yes 2 No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | AT 2438946 B7 | AUGUST 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON JENKINS, MD UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PKWY BALTIMORE, MD 21218

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | [signature] D. Sparks |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27061

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph A Bowers
2. Date of Death (Month, Day, Year): August 19, 2001
3. Time of Death: 11:40 AM
4a. Facility Name (If not institution, give street and number): Balto VAMC Extended Care Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 216-03-2562
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 5, 1912
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3435 Cliftmont Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coppersmith
16b. Kind of Business/Industry: Ship Repair Industry
17. Father's Name (First, Middle, Last): Joseph F. Bowers
18. Mother's Name (First, Middle, Maiden Surname): Margaret Novak
19a. Informant's Name/Relationship (Type, Print): Janice Bowers (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3435 Cliftmont Avenue Baltimore, Maryland 21213
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Mary Cemetery
Date: August 22, 2001
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Martha Lassahn Chapoti
22. Name and Address of Facility: Lassahn Funeral Home, Inc. 7401 BelAir Road Baltimore, Maryland 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David J Loreto MD
29c. License number: D37070
29d. Date signed (Month, Day, Year): August 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J Loreto M.D. Balto VAMC Extended Care

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27062

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alma Carter

2. Date of Death: Month August Day 21st Year 2001

3. Time of Death: 9:15 Am

4a. Facility Name (If not Institution, give street and number): HARBOR HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-30-9421

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/17/1934

9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2615 Carver Rd

10f. Zip Code: 21225

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher's Aide

16b. Kind of Business/Industry: Public School Baltimore City

17. Father's Name (First, Middle, Last): Fred McElveen

18. Mother's Name (First, Middle, Maiden Surname): Barzella Hanna

19a. Informent's Name/Relationship (Type, Print): Anthony R. Carter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 York Ct., Baltimore, MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Cemetery Date: 08-25-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Andrea L. McFadden

22. Name and Address of Facility: March Funeral Home 1101 E. North Ave., Baltimore, MD 21202

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heert tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immedlete Cause (Final diseese or condition resulting in death)

a. metastatic Colon Cancer — 4 months

Due to (or as e consequence of):

b. liver metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events rasulting in death) Last

Due to (or es a consequence of):

c. Hepatic Encephalopathy

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

Deep venous thrombosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner ot Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place ot Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: [signature]

29c. License number: D39041

29d. Date signed (Month, Day, Year): August 21st 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAYATRI NIMMAGADDA 3001 S. Hanover Street MD 21225 Harbor Hospital Center Baltimore

**State Registrar**

31. Data filed (Month, Dey, Year): AUG 24 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2001 27063

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GRACE CRANE | | | 2. DATE OF DEATH (Month, Day, Year): AUGUST 18, 2001 | 3. TIME OF DEATH: 7:45 AM M |
| 4. SOCIAL SECURITY NUMBER: 095-09-6118 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 28, 1917 | 8. BIRTHPLACE (State or Foreign Country): California |
| 9a. FACILITY NAME (If not institution, give street and number): Glen Meadows Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Arm | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Glen Arm | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 11630 Glen Arm Road | | 10f. ZIP CODE: 21057 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4 or 5+): unk | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): office worker | 16b. KIND OF BUSINESS/INDUSTRY: unk | |
| 17. FATHER'S NAME (First, Middle, Last): Arthur Crane | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel Chope | |
| 19a. INFORMANT'S NAME (Type/Print): Glen Meadow Nursing Home | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11630 Glen Arm Road, Glen Arm, MD 21057 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S. Wade, Director | 22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE CARDIAC FAILURE | 2yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. COPD | 2yr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CHEMOTHERAPY WITH DOXORUBICIN | 3yr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CHRONIC LYMPHOCYTIC LEUKEMIA | 4y |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA
DEPRESSION

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R Gopalan MD | 29c. LICENSE NUMBER: D51229 | 29d. DATE SIGNED (Month, Day, Year): 8/20/2001 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAMANA GOPALAN MD 2 E. ROLLING CROSSROADS #159 BALTIMORE MD 21228 | | |
| 31. DATE FILED (Month, Day, Year): AUG 24 2001 | 32. REGISTRAR'S SIGNATURE: Geneva G Sparks | |

DHMH-16 Rev 1/89

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27064

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Oliver Christmas

2. Date of Death: Month: August Day: 22 Year: 200

3. Time of Death: 10:45 AM

4a. Facility Name *(If not institution, give street and number)*: Baltimore V.A. Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-10-8096

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 5, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 828 Brooks Lane

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: mail clerk

16b. Kind of Business/Industry: US postal system

17. Father's Name *(First, Middle, Last)*: Oliver J. Christmas Sr

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida May Mason

19a. Informant's Name/Relationship *(Type, Print)*: Sheila Christmas/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 828 Brooks Lane Baltimore, MD 21217

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P13415

29d. Date signed *(Month, Day, Year)*: August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank Duy Duc Trinh, 10 North Greene St. Baltimore MD 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: Geneva D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27065

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia Frances Cozad

2. Date of Death: Month: August Day: 21 Year: 2001

3. Time of Death: 10:20 a.m.

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-60-5773

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 31, 1925

9. Birthplace (State or Foreign Country): Washington, DC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 101 Odendhal Avenue, Apt. 612

10f. Zip Code: 20877

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Coast Guard

17. Father's Name (First, Middle, Last): James Cozad

18. Mother's Name (First, Middle, Maiden Surname): Katherine Morrison

19a. Informent's Name/Reletionship (Type, Print): George W. Allen (Nephew)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1803 Wood Rail Drive, Millersville, MD 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Epiphany Episcopal Cem.

Date: 08/25 2001

20c. Location - City or Town, State: Odenton, MD

21. Signature of Funeral Service Licensee: Patel J. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat diseese or condition resulting in death)

a. Aspiration Pneumonia — hours

Due to (or es a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and piece, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Steven J. Dolinsky

29c. License number: 20148

29d. Date signed (Month, Day, Year): August 21, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Steven Dolinsky, MD, 911 Russell Avenue, Gaithersburg, MD 20877

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: pending D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27066

**Physician /Medical Examiner**

1) Decedent's Name (First, Middle, Last): LEROY CROMER

2. Date of Death: Month AUGUST Day 22 Year 2001

3. Time of Death: 11:11A M

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 249-36-4723

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 12, 1928

9. Birthplace (State or Foreign Country): S. CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 3503 W. Franklin

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Electric Co.

17. Father's Name (First, Middle, Last): SAM CROMER

18. Mother's Name (First, Middle, Maiden Surname): Margaret Johnson

19a. Informant's Name/Relationship (Type, Print): Dorothy Cromer - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3503 W. Franklin St. Balto., MD 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): Arbutus Mem. Pk.

Date: 8-27-01

20c. Location - City or Town, State: Arbutus, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: GARY P. HARRIS Funeral Home P.A. 270 Frederick Pass Balto., MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. CARDIAC ARRHYTHMIAS — 1 DAY

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Appea MD

29c. License number: 14441

29d. Date signed (Month, Day, Year): AUGUST, 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LOUISA APPEA-DANQUAH, 900 CATON AVE, BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME * CROMER, LEROY

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #7 PER FH G798 8/29/01 JH

# Certificate of Death

Reg. No. 2001 27067

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John William Cunningham
2. Date of Death: Month August Day 20 Year 2001
3. Time of Death: 4:20 PM
4a. Facility Name (If not institution, give street and number): 302 Jeanwood Court
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-26-2885
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): ~~63~~ 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 11, 1938
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 302 Jeanwood Court
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No 1956-57
If Yes, Give Year or Dates: 1961-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 Years
Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Delivery
16b. Kind of Business/Industry: Automotive Parts

17. Father's Name (First, Middle, Last): Thomas Cunningham
18. Mother's Name (First, Middle, Meiden Surname): Helen Arnold

19a. Informant's Name/Relationship (Type, Print): Mrs. Doris Cunningham (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Jeanwood Ct. Dundalk, MD 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gardens of Faith Cem.
Date: 8/24/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Reagan E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disaasa or condition resulting in death)
a. Colon Cancer metastate

Due to (or as a consequence of):
b. To Liver

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one)
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Homa 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Cartifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the tima, date and place, and due to the ceuse(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Mayer Gorbaty MD
29c. License number: 027938
29d. Date signed (Month, Day, Year): 8/24/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Mayer Gorbaty MD. 795 Aquahart Rd Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Bonnie D Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27068

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Dolores M. Clarke | August 19 2001 | 5:45 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sunrise Assisted Living | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-26-9170 | 1☐M 2☑F | 71 Yrs. | | | 02/06/1930 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Perry Hall | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 36 Borgia Court | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 4 | Employment Services Counselor | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Ross | Marie Bosse |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Martin Clarke Son | 361 Whitfield Road, Catonsville, MD 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | 8/23/2001 | Beltsville, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. atherosclerotic disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D-53636 | August 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kevin Bishoff Carlson 3460 Ellicott Center Drive Ellicott City MD 21043

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Koran R. Clarrett
CJ
01-4789-005

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #20b PER FH verb G798 8/29/01 TH

# Certificate of Death

Reg. No. 2001 27069

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): KORAN R. CLARRETT

2. Date of Death: Month August, Day 20, Year 2001

3. Time of Death: 08:21 P.M.

4a. Facility Name (If not institution, give street and number): Rear of 4312 Flint Hill Drive

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

5. Social Security Number: 077-58-6281

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 28 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 27- 73

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: NY

10b. County:

10c. City, Town or Location: NEW YORK

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1505 PARK AVENUE APT16C

10f. Zip Code: 10029

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOTEL

16b. Kind of Business/Industry: SUPERVISOR

17. Father's Name (First, Middle, Last): SAMUEL BROWN

18. Mother's Name (First, Middle, Maiden Surname): LORETTA CLARRETT

19a. Informant's Name/Relationship (Type, Print): LORETTA CLARRETT (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2870 TWIN BROOK DR. - ATLANTA, GA. 30319

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): ROSE HILL CEMETERY

Date: 8/25/01

20c. Location - City or Town, State: LINDEN NJ.

21. Signature of Funeral Service Licensee: Carlton C. Douglas

22. Name and Address of Facility: 1701 McCULLOH ST - BALTO. MD. 21217 CARLTON C. DOUGLASS FUNERAL SERVICE P.A.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE GUNSHOT WOUNDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Found 8/20/01

28b. Time of Injury: Found 8:14 P. M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State): rear of 4312 Flint Hill Drive Owings Mills, MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-4794-510
B.K.S
DENNIS CHASE

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27070

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Dennis Chase | AUG. 21, 2001 | 0847 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 309 EAST FEDERAL STREET APT. F-401 | BALTIMORE | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 571-08-6284 | 1☒ M 2☐ F | 40 Yrs. | | | June 28 1961 | Georgia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | n/a | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1601 Guilford Ave. | 21202 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Artist | Art |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ernest Roy Chase | Mary Lee Davis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Santarelli/mother | 200 Mulberry Lane Baltimore MD 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Bayview Crematory | 8/22/01 | Baltimore MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. Terry Connelly | ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HANGING | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 8/21/01 | 8:05 A M | 1☐ Yes 2☒ No | SUBJECT FOUND HANGING |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| HOME | 309 EAST FEDERAL STREET BALTIMORE, MD |

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. M. Titus | O.C.M.E | AUG. 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [illegible] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#26 perPHYG798 8/24/01 **Certificate of Death** Reg. No. 2001 27071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Christy Crismer
2. Date of Death Month August Day 19, Year 2001
3. Time of Death: 6:30 AM
4a. Facility Name (If not institution, give street and number): 259 Cider Court
4b. City, Town, or Location of Death: Severna Park
4c. County of Death: Anne Arundle

Funeral Director

5. Social Security Number: 217-24-9203
8. Sex: 1☐M 2☒F X
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 10, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐Yes 2☒No XX
10e. Street and Number: 950 A. Pentwood Road
10f. Zip Code: 21014
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Loan Officer
18b. Kind of Business/Industry: S. S. A. Baltimore Federal Union

17. Father's Name (First, Middle, Last): John C. Christy
18. Mother's Name (First, Middle, Maiden Surname): Ada Thompson

19a. Informant's Name/Relationship (Type, Print): Deborah Jordan (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 259 Cider Court Severna Park, MD 21146

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: August 22, 2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Joseph J Kellner MOO 333
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown, MD 21133-4784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease — Approximate Interval Between Onset and Death: 4yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) Daughter's Home

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D28136
29d. Date signed (Month, Day, Year): 8-20-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert Duncan 615 Mc Phail Rd Bel Air, Md

State Registrar

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Penna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G798 8/29/01 JH

# Certificate of Death

2001 27072 Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner** | **Funeral Director** | **To Be Completed by Funeral Director**

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Virginia E. Chenoweth | | 2. Date of Death Month Day Year: August 21, 2001 | 3. Time of Death: 2:45 PM |
| 4a. Facility Name (If not institution, give street and number): Manor Care-Roland Park | 4b. City, Town, or Location of Death: Baltimore | 4c. County of Death: N/A | |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-01-9074 | 1☐M 2☒F | 83 Yrs. | | | Oct. 10, 1917 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3838 Roland Avenue | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | HOMEMAKER | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Rinehart | Mary Hasson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paul Chenoweth Son | 3291 Greenway Drive Westminster, MD 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore-Washington Crematory | 8/23 | Laurel, Maryland |

21. Signature of Funeral Service Licensee: Terry H. Caputo

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner** | **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic breast cancer | 5 yrs |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Congestive heart failure | yrs |
| Due to (or as a consequence of): | | |
| | c. atrial fibrillation | yrs |
| Due to (or as a consequence of): | | |
| | d. Coronary artery disease | yrs |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Marguerite T. Moran MD | D0009093 | 8/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marguerite T Moran 1809 Thornbury RD Balto, Md

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Donna D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

01-3053-510

REPLACEMENT

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27073

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Jack Thomas Wise, Jr. | June 01 2001 | 08:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 200 South President Street | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| unk | 1[X] M 2[ ] F | 36 Yrs. | | | Mar 18, 1965 | Baltimore City |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore City | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1909 E. Lanvale Street | 21213-2410 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | laborer | unk |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jack Thomas Wise, Sr | Priscille Tinsley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ethel Wise/stepmother | 1909 E. Lanvale Street Baltimore, MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[X] Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Narcotism

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[X] Yes 2[ ] No | 1[X] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[X] Yes 2[ ] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | 03-28-03 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R. Fowler, M.D. 111 Penn Street, Baltimore, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| APR 0 2 2003 | Barbara G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27074

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: KURT WALTER DIEFENBACH

2. Date of Death (Month, Day, Year): August 16, 2001

3. Time of Death: 4:35 AM

4a. Facility Name *(If not institution, give street and number)*: Shore Home Hospice

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 214-36-4123

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 31, 1922

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: MD

10b. County: Talbot

10c. City, Town or Location: Saint Michael's

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 222 Tyler Avenue

10f. Zip Code: 21663

10g. Citizen of What Country?: Germany

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: auto parts specialist

16b. Kind of Business/Industry: automotive

17. Father's Name *(First, Middle, Last)*: Frederiech Diefenbach

18. Mother's Name *(First, Middle, Maiden Surname)*: Eliese Puth

19a. Informant's Name/Relationship *(Type, Print)*: Erna Diefenbach/spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 222 Tyler Avenue Saint Michael's, MD 21663

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Nonsmall cell lung cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* hospice house

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D39887

29d. Date signed *(Month, Day, Year)*: 8/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Smith, M.D. 29466 Pintail Drive, Suite #5 Easton, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: Lenora D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a perPHYG799 **Certificate of Death** 9/14/01 EW Reg. No. 2001 27075

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Mary | A. | Davis | August | 20 | 200 | 1 2108 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital, | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 199-20-8267 | 1☐M 2☒F | 75 Yrs. | | | 06 26 26 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6514 Eberle Drive Apt 103 | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th grade | na | Housekeeping | Newman Center |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lamar Key | Margaret Johnson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donna Parker-Daughter | 3817 Glenyle Ave, Baltimore Md 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | King Memorial Park | 8/24/01 | Randallstown, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dale March | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DISSECTING THORACIC ANEURYSM ~~thoracoabdominal Dissection~~ | 11 ~~minutes~~ Hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. ARTERIOSCLEROTIC VASCULAR DISEASE ~~hypertension~~ | ~~12~~ 5 Years ~~12 years~~ |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~None~~ HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | 8957 | August 20, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tec Chang MD Sinai Hospital

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Patient known as Mary A Davis

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27076

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Mildred Rae Donovan | August 23, 2001 | 8:00 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Nursing Center | Baltimore | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-01-9549 | 1☐ M 2☒ F | 90 Yrs. | | | October 28, 1910 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | n/a | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5616 Loch Raven Blvd., Apt. 1A | 21239 | USA. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | n/a | Homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Leon Stephen Lynch Morrow | Nellie Isabelle Dempsey |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thelma I. Martin-sister | 4910 Morello Rd., Baltimore, MD 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Hilltop Service Corporation | 8/24/01 | Towson, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ William G. Dau | Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Balt., MD 21214 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure

Due to (or as a consequence of):

b. Renal insufficiency — More than

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. — 3 Months

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Suresh Tripuraneni | D 30661 | August 24th 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIREESH K. TRIPURANENI
5601 Loch Raven Blvd, Baltimore, Md - 21239.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Deborah D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27077

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Eva | Dawson | August 21, 2001 | 11:50 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care Towson | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 178-18-7568 | 1☐ M 2☒ F | 81 Yrs. | | | 04/16/1920 | PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8909 Reisterstown Road | 21208 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Ad Taker | Philadelphia Newspaper/ Inquirer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frederick Unrath | Eva Ritchie |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy Zengerl/daughter | 17615 Date Palm Court N. Fort Myers, Florida 33917 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Whitemarsh Mem. Park | 08/25/2001 | Prospectville, PA |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ Stephen D. Coster | MO1122 | Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. coronary artery disease | 40 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. hypertension | 50 years |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D41104 | 8.22.01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted Houk MD 7825 York Rd Towson MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ D. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27078

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BENJAMIN EBEL
2. Date of Death — Month: AUG. Day: 18 Year: 2001
3. Time of Death: 6:00 P.M.
4a. Facility Name (If not institution, give street and number): 1555 GRUNDEY ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-32-8778
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 3, 1924
9. Birthplace (State or Foreign Country): POLAND

Usual Residence of Decedent

10a. State: MD. 10b. County: N/A 10c. City, Town or Location: BALTIMORE 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1555 GRUNDEY ST. 10f. Zip Code: 21224 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BARBER

16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): JOSEPH EBEL

18. Mother's Name (First, Middle, Maiden Surname): ROSA KUZNERSKI

19a. Informant's Name/Relationship (Type, Print): ANNE BRODERICK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3806 MACALPINE RD. ELLICOTT CITY, MD 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): OAKLAWN CEM. Date: AUG 23 2001

20c. Location - City or Town, State: BALTO. CO., MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: HOFFMANN-SKARDA 3218 HUDSON ST. BALTIMORE, MD 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| a. Immediate Cause (Final disease or condition resulting in death) | MYOCARDIAL INFARCTION | 2 hrs |
| Due to (or as a consequence of): b. | CORONARY ARTERY DISEASE | 1 yr |
| Due to (or as a consequence of): c. | HTN | 10 yr |
| Due to (or as a consequence of): d. | DIABETES | 10 yr |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul T. Barbera MD

29c. License number: D 37708

29d. Date signed (Month, Day, Year): 08-20-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL T. BARBERA M.D. 3243 ELLIOTT ST, BALTO, MD. 21224

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Bernard D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

83

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 27079

Reg. No.

AMND ITM#1&5-19B PR. K.B. G798 8-24-01 JAB

BG Everette

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): B.G. EVERETTE

2. Date of Death (Month, Day, Year): May 13, 2001

3. Time of Death: 1455 pm

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: NONE

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months: 7 Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): 4/17/01

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTO., CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2014 BRADDISH AVE.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INFANT

16b. Kind of Business/Industry: INFANT

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): LATASHA EVERETTE

19a. Informant's Name/Relationship (Type, Print): LATASHA EVERETTE / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2014 BRADDISH AVE. BALTIMORE, MD. 21216

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sinai Hosp

Date: 5-15-01

20c. Location - City or Town, State: Balto md

21. Signature of Funeral Service Licensee: [signature] PATT

22. Name and Address of Facility: 2401 W. Belvedere Ave Sinai Hosp 2405

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Probable Sepsis — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Renal Failure — 2 days

Due to (or as a consequence of):

c. Extreme Prematurity — 27 days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Neonatologist

29c. License number: D0040362

29d. Date signed (Month, Day, Year): May 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas O'Brien, M.D. Sinai Hospital of Baltimore 2401 W. Belvedere Ave. Baltimore, Md. 21215

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27080

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| NAIDA | EISENBUD | August 22 2001 | 945 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 080-03-5423 | 1☐ M 2☒ F | 82 Yrs. | | | MAY 21, 1919 | NEW YORK |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| FL | COLLIER | NAPLES | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3315 GOLFSIDE DR. | 34110 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 3 | NURSE | MEDICAL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| EUGENE ROBARE | EDITH TAYLOR |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DR. LEON EISENBUD (HUS.) | 3315 GOLFSIDE DR. NAPLES, FL 34110 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | HILLTOP SERV. CORP. | 8/23/2001 | TOWSON, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Burton H. Levinson | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Bowel — 7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension — 7 days

Due to (or as a consequence of):

c. Septic Shock

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jonathan Hefner MD | RES 000 | August 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JONATHAN HEFNER MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

EISENBUD, NAIDA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27081

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ALICE FOSTER | 8 / 22 / 01 | 12:35 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2739 EAST PRESTON STREET | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-14-8373 | 1☐ M 2☑ F | 82 Yrs. | | | SEPTEMBER 3, 1918 | SOUTH CAROLINA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | | BALTIMORE | 1☑ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2739 EAST PRESTON STREET | 21213 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced | 1☐ Yes 2☑ No If Yes, Give Year or Dates: | 1☐ Yes 2☑ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12): 6th | College (1-4or 5+) | HOMEMAKER | PRIVATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ADAM JOHNSON | CELIA LIGHTNER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WILLIE B. FOSTER / SON | 2731 EAST PRESTON STREET BALTIMORE, MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | ARBUTUS CEMETERY | AUGUST 27, 2001 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | MD0015 | 22. Name and Address of Facility |
|---|---|---|
| ▶ [signature] | | VAUGHN C. GREENE FUNERAL SERVICE 4905 YORK ROAD BALTIMORE, MD 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC BREAST CANCER | 10 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☑ No | 1☐ Yes 2☑ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Don R. Martin MD | D0040997 | 8/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DON R. MARTIN, M.D. JOHNS HOPKINS HOSPITAL

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Geneva D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS#20b,c per fh G798 083001 ss

# Certificate of Death

Reg. No. 2001 27082

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES FISHER
2. Date of Death: Month AUGUST Day 22 Year 2001
3. Time of Death: 0546A M
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-20-9461
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 29, 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3806 MARRIOTTSVILLE RD.
10f. Zip Code: 21133
10g. Citizen of What Country? USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONGSHOREMAN
16b. Kind of Business/Industry: STEAMSHIP TRADE

17. Father's Name (First, Middle, Last): WALTER GANT
18. Mother's Name (First, Middle, Maiden Surname): LOUVINIA FISHER

19a. Informant's Name/Relationship (Type, Print): LOUVINIA VALION (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2555 EDMONDSON AVE., BALTO, MD 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ~~GARRISON FOREST~~ Arbutus Memorial Park
Date: 8-28-01
20c. Location - City or Town, State: Baltimore, MD ~~OWINGS MILLS, MD.~~

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): RENAL FAILURE
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C. Ravi MD
29c. License number: D37333
29d. Date signed (Month, Day, Year): AUGUST 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: D Sparks

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27083

Frater, Stella

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): STELLA HELENA FRATER
2. Date of Death (Month, Day, Year): August 22, 2001
3. Time of Death: 2:15PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 235-18-4900
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 2, 1909
9. Birthplace (State or Foreign Country): W. VA.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 350 HORNEL STREET
10f. Zip Code: 21224
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+): UNKNOWN
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): SAMUEL ARBAUGH
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): ERMA G. GROMACKI/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 350 HORNEL STREET, BALTIMORE, MARYLAND 21224

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEMETERY
Date: 8/25/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Elizabeth Skanski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 7days |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harvinder Singh Arora
29c. License number: P14172
29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Harvinder Arora 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: D. Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27084

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ruby M. Finnegan | August 21, 2001 | 9:00A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 602 Glenrock Road | Pikesville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-18-6844 | 1☐M 2☒F | 93 Yrs. | | | July 11, 1908 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Pikesville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 602 Glenrock Road | 21208 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unk | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Martin Seiler | Ruby Goss |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy Cowan Daughter-in-Law | 5507 Whitewood Road; Baltimore, Maryland 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment | Loudon Park Maus. | 8/23/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00869 | Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Hypertension | 10+ years |
| | c. Due to (or as a consequence of): Diabetes Mellitis | 10+ years |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D50517 | 8/21/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1120 North Rolling Rd Baltimore MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27085

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| FRANCES M. FRANZ | AUGUST 22 2001 | 10:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1513 Shore Rd. | Baltimore County | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218 14 0170 | 1☐ M 2☒ F | 78 Yrs. | | | March 16, 1923 | Brooklyn, New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1513 Shore Road | 21220 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | N/A | Housewife | House-Keeping/ Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William G. Borum | Esther V. Grouney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward H. Franz, Jr. (Son) | 1106 Emeral Drive BelAir, Maryland 21014 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Gardens Of Faith Cemetery | August 25, 2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Walter Lassahn Chipock | Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finet disease or condition resulting in death) | a. Transitional Cell Bladder Cancer | 8 mo |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequenca of): b. | |
| | Due to (or as e consequenca of): c. | |
| | Due to (or as a consequence of): d. | |

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. tf yes, outcome of pregnency | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnancy 4☐ Pregnent at time of deeth 5☐ Other (specify) 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probsbly 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residenca 8☐ Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29e. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) and manner as steted. 2☐ Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Richard L. Hissig | D36614 | 8/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard L. Hissig 7005 Osler Dr. Suite 302 Towson MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | G. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-4792-047
crn
Albert Joseph Gossman, Jr.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 082801:ITEMS#23a,27,28a-f per ME G798 SS **Certificate of Death**

Reg. No. 2001 27086

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Albert Joseph Gossman, Jr.

2. Date of Death — Month: August; Day: 20; Year: 2001

3. Time of Death: 9:09 P.M.

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: Unknown

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Oct. 5, 1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2 North St.Louis Apt 5

10f. Zip Code: 21842

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance

16b. Kind of Business/Industry: Hospitality

17. Father's Name *(First, Middle, Last)*: Albert Joseph Gossman, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Harriet Alverta Lugenbeel

19a. Informent's Name/Relationship *(Type, Print)*: Scott Gossman / brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2137 Harkins Road., Pylesville, MD 21132-1614

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 8/24/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures DR., Towson, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC AND ETHANOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury *(Month, Day Year)*: Found: 8-20-01

28b. Time of Injury: Found at: 8:31p M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Found at home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2 North St. Louis Ave., Ocean City,MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM# 5-8&10 PR. F.H. G798.8-24-01 JAB

# Certificate of Death

2001 27087
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Shirley | Hall | August 19 2001 | 0132 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northwest Hospital | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~219-28-3696~~ 215-42-9323 | ~~XM~~ XF | ~~54~~ 75 Yrs. | | | 09 04 ~~46~~ 12-9-25 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10e. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| ~~MD~~ | NA | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5218 Pembroke Ave | 21207 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 1 ☐ Yes XX No If Yes, Give Yeer or Detes: | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | na | Teacher's Aid | School System |

| 17. Fether's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Unknown | Unknown |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cynthia Durham-Daughter | 5218 Pembroke Ave, Baltimore Md 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | King Memorial Park | 8/24/01 | Randallstown, Md |

21. Signature of Funeral Service Licensee: Mary C. Branch

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary Artery Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | Due to (or as a consequence of): b. Generalized Arteriosclerosis | |
| | Due to (or es a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 X No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Diabetes mellitus

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 X No |

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Rolando M. Sabundayo, MD | D0004832 | August 23, 2001 |

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
ROLANDO M. SABUNDAYO, MD 405 Frederick Road Suite 162, Baltimore, MD. 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Penny D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27088

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WALTER HOOD
2. Date of Death: Month August Day 20 Year 2001
3. Time of Death: 1:10 PM
4a. Facility Name (If not institution, give street and number): HCR MANOR CARE TOWSON
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 220-07-1200
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 11, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2810 B Kings Ridge Rd
10f. Zip Code: 21234
10g. Citizen of What Country? USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION
16b. Kind of Business/Industry: ARMCO Steel
17. Father's Name (First, Middle, Last): Walter F. Hood
18. Mother's Name (First, Middle, Meiden Surneme): Alice Hoffman
19a. Informant's Name/Relationship (Type, Print): Sharon Hepding
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 2813 Putty Hill Ave. Baltimore, Md 21234
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Moreland Mem. Park
Date: Aug 23 2001
20c. Location - City or Town, State: Parkville Maryland
21. Signature of Funeral Service Licansee: Kenta S Wells
22. Nama and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona cause on each line. Approximata Interval Batween Onset and Deeth

Immediate Cause (Final diseasa or condition resulting in death)
a. METASTATIC CARCINOMA
Due to (or es a consequenca of):
b. Pulmonary CARCINOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contributa to the causa of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D24100
29d. Date signed (Month, Day, Year): 08-22-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.L. PRABHAKAR MD 300 ARMORY PLACE BAL, MD 21221

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

RR

RR 10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27089

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frances M. Hanes

2. Date of Death: Month August Day 21 Year 2001

3. Time of Death: 2:20 am

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 237-09-3083

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.6,1916

9. Birthplace (State or Foreign Country): NorthCarolina

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6 Venturi Road

10f. Zip Code: 21220

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Line Worker

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Madrid F. Graves

18. Mother's Name (First, Middle, Maiden Surname): MAry E. Soffner

19a. Informant's Name/Relationship (Type, Print): Paula M. Sudbrook /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3700 Denton Court Abingdon MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HollyHill Cemetery | Date: 8/23/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D43725

29d. Date signed (Month, Day, Year): August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

August 21, 2001 2:20 a.m.
Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,
Frances Hanes

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27090

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Hilda C. Harlow | August 22, 2001 | 1:20 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 224-24-0542 | 1☐M 2☒F | 85 Yrs. | | | Sep. 9, 1915 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 117 Bennett Road | 21221 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 9 | | Machine Operator | Crown Cork & Seal |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Bradley Campbel | Eva King |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara Harlow (daughter) | 117 Bennett Road, Essex, Maryland 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bel Air Mem. Gardens | 08/25/2001 | Bel Air, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Septic Shock | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Acute Upper Gastrointestinal Bleed | 24 Hours |
| | Due to (or as a consequence of): | |
| | c. Cerebrovascular Accident with Left Hemiparesis | 10 Months |
| | Due to (or as a consequence of): On Coumadin Therapy | |
| | d. Congestive Heart Failure with Systolic Dysfunction Ejection Fraction 18% | 3 Months |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☑ | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| 2☐ | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D 28717 | August 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen Selinger, M.D. 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ B. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HARLOW, HILDA

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Items#9,11,12,16a-b,17,18,19a-b perABG 79 **Certificate of Death** 9/5/01 EW Reg. No. 2001 27091

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VINCENT JONES

2. Date of Death Month: AUGUST Day: 18, Year: 2001

3. Time of Death: 12:09 PM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 217-64-7360

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 1, 1956

9. Birthplace (State or Foreign Country) ~~unk~~: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 833 N. Gilmore Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status ~~unk~~: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No ~~unk~~ If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ~~unk~~: Home Improvements

16b. Kind of Business/Industry ~~unk~~: Self-Employed

17. Father's Name (First, Middle, Last) ~~unk~~: Jessie Lee Jones

18. Mother's Name (First, Middle, Maiden Surname) ~~unk~~: Doris Morton

19a. Informant's Name/Relationship (Type, Print): Doris M. Jones (Mother) ~~Maryland General Hospital~~

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2441 McCullough ST Balto Md 21217 ~~827 Linden Avenue Baltimore, MD 21201~~

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ACUTE RENAL FAILURE

Due to (or as a consequence of):
c. PNEUMONIA

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 89398

29d. Date signed (Month, Day, Year): 08-18-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rashid Haq M.D. C/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Vincent Jones

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27092

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Robert Thomas Kane | August 23, 2001 | 1:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4458 Cole Farm Road | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-38-4487 | 1☒M 2☐F | 61 Yrs. | | | July 11, 1940 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4458 Cole Farm Road | 21236 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | | Heating & Air Cond. Tech. | State of Maryland |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas John Kane | Evelyn Bell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Nancy Kane (wife) | 4458 Cole Farm Road, Baltimore, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Oak Lawn Cemetery | 8/27/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mark T. Zug | Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Lung Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☑Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Jonny Waterbury, M.D. | DO 9559 | 8/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARRY WATERBURY, MD, JHBMC. 4940 EASTERN AVE., BALT. 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Jeanne M Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27093

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kenneth Heath Kitchen
2. Date of Death (Month, Day, Year): August 23, 2001
3. Time of Death: 1 05 am
4a. Facility Name (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-14-6875
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 25, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 707 Maiden Choice Lane
10f. Zip Code: 21228
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Tax

17. Father's Name (First, Middle, Last): Ardelle Kitchen
18. Mother's Name (First, Middle, Maiden Surname): Ruby Boyd Heath

19a. Informant's Name/Relationship (Type, Print): Doris M. Kitchen - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Maiden Choice Lane, Catonsville, Maryland 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.
Date: 8/25/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann J Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andres J Salazar MD
29c. License number: D51051
29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar, 711 Maidenchoice Lane, Catonsville, MD, 21228

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Kenneth Kitchen

10

**State Registrar**

31. Date filed (Month, Day, Year): AUG 2 4 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27094

**Physician / Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY KENOY
2. Date of Death (Month, Day, Year): AUG 16 2001
3. Time of Death: 8:30PM
4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-22-1939A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 26, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3320 Benson Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): John Martin Conelius
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Burns

19a. Informant's Name/Relationship (Type, Print): Sheila Lafayette Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2270 Duvall Road, Woodbine, MD 21797

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park — Date: 8/21/01
20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD 21228

**Physician / Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Urinary tract infection — 2weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus; CVA, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D52544
29d. Date signed (Month, Day, Year): Aug 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin S. Lee, M.D. 760 George Rd #204 Catonsville MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27095

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph T. Kantorski | Aug 22, 2001 | 7:15 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 700 Sawyer Court | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-28-9516 | 1 ☐ M 2 ☐ F | 69 Yrs. | | | | | March 1, 1932 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Towson | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 700 Sawyer Court | 21286 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datea: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Accountant | Financial |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Joseph T. Kantorski | Stella Jedrzejczak |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Lenore M. Kantorski (Wife) | 700 Sawyer Court Towson, Maryland 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Dulaney Valley Mem. Gdns. | 8/25/2001 | Timonium Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael Buck Jr. | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — Approximate Interval Between Onset and Death: 1 YEAR

Due to (or as a consequence of):

b. HIGH BLOOD PRESSURE — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yea 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time ot death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause ot death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ Michael J. Minnsofo MD | D31189 | AUGUST 22, 2001 |

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

MICHAEL J. MINNSOFO, MD, 8813 WALTHAM WOODS RD, BALTIMORE MD 21234

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Pamela G. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar Amend Item#15 perFHG798 8/24/01 LW

Reg. No. 2001 27096

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Della Marie Linares | August 22, 2001 | 1:20 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Nursing Center | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-26-1714 | 1☐M 2☒F | 74 Yrs. | | | Oct 24, 1926 | AL |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Fallston | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2102 Givenswood Drive | 21047 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12): 2 | College (1-4or 5+): 2 | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ralph Clyde Terry | Della Waldrop |

| 19e. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert Freeman /Son | 2102 Givenswood Drive, Fallston, MD 21047 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Aug 24 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Holly A Johnmann | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Diabetes with gastroparesis

Due to (or as a consequence of):

b. Cerebrovascular accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Dementia

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Joint disease

| 23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown | | |
|---|---|---|
| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No | |

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D31464 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shoaib A. Hashmi, 821 N. Eutaw St Suite 308, Balt. MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ per FHG S Sparks |

**To be Completed by Funeral Director**

Della Linares
**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27097

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN WALTER LEIMBACH
2. Date of Death Month: AUGUST Day: 23 Year: 2001
3. Time of Daath: 10:12 AM
4a. Facility Name (If not institution, give street and number): 800 Hilton Avenue
4b. City, Town, or Location of Daath: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-46-6751
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 58 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): April 16,1943
9. Birthplace (Stata or Foraign Country): Maryland

Usual Residance of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 800 Hilton Avenue
10f. Zip Coda: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: white

15. Decedant's Education (Specify only highest grade compiated)
Elamentary/Secondary (0-12):
College (1-4or 5+): 5+
18a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired): Bellboy
18b. Kind of Businass/Industry: Hotel

17. Father's Name (First, Middle, Last): John Walter Leimbach,Jr
18. Mothar's Nama (First, Middle, Maiden Surname): Annella Peters

19a. Informant's Name/Ralationship (Type, Print): Jeanne Peters- cousin/ P.R.
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 1004 Hilton Avenue, Catonsville, Md. 21228

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Nama of cematary, crematory or othar place): St. John's Cemetery
Data: 08/27/01
20c. Location - City or Town, State: Ellicott City, Md.

21. Signature of Funaral Service Licansa: [signature]
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, Md.21228

**Physician /Medical Examiner**

23a. Part I. Enter tha disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath):
a. Cerebral Vascular Accident — hours
Dua to (or as a consequence of):
Sequentially list conditions, if any, taading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequanca of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fatat death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of death 5 [ ] Othar (specify) 9 [ ] Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa given in Part I.

23a. Did tobacco usa contributa to the cause of daath? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performad? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No
26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Rasidence 6 [ ] Othar (Specify)
27. Manner of Death: 1 [X] Naturat 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describa how injury occurrad
26a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] Cartifying Phyaician: To the best of my knowladge, death occurrad at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2 [ ] Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and ptace, and dua to the causa(s) and mannar stated.
29b. Signature and title of cartifiar: [signature] MD
29c. Licansa numbar: D36786
29d. Data signad (Month, Day, Yaar): August 24, 2001

30. Name and address of parson who complatad cause of death (Item 23a) (Type, Print): 7061 Deepage Drive, Suite 104, Columbia MD 21044

**State Registrar**

31. Data filed (Month, Day, Yaar): AUG 24 2001
32. Registrar's Signatura: [signature]

DHMH 17 Rav 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

AMEND ITEM##4b PERFH G798 8/28/01 JH

Amend Item #14,8/23/01,per F.H.,G798,gap

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27098

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Vernon Russell Lewis
2. Date of Death: Month: August Day: 21 Year: 2001
3. Time of Death: 10:30
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-03-4528
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-2-19[illegible]
9. Birthplace (State or Foreign Country): Baltimore Md.

Usual Residence of Decedent

10a. State: Md.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6907 Holabird Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1942
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: ~~Black~~ White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): master Mech Foreman
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Neme (First, Middle, Last): Russell C. Lewis
18. Mother's Neme (First, Middle, Maiden Surneme): Adolphine Peroty

19a. Informent's Neme/Relationship (Type, Print): Vernon R. Lewis Jr.
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1401 Provincetown Ct. Virginia Beach 23456

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Sacred Heart of Jesus
Date: 8-25-01
20c. Location - City or Town, State: German Hill Rd.

21. Signature of Funeral Service Licensee: Wesley Chavis Jr.
22. Name and Address of Facility: Chavis Funeral Home 2007 Eastern Ave. Baltimore 21231

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

August 21, 2001 10:20 a.m.
Baltimore, Maryland 21215-0020

Vernon Russell Lewis
Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): a. Metastatic Cancer

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Dey, Year): August 21, 2001

30. Name end address of person who completed cause ot death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [illegible] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27099

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Leonard Frederick Lauber | August 20, 2001 | 3:02p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll County General Hospital | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-0240 | 1[X] M 2[ ] F | 90 Yrs. | | | Nov 7, 1910 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Westminster | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 200 St. Luke Circle | 21158 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced | 1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1933-36 | 1[ ] Yes 2[X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | n/a | Machinist | Computers/Race Tracks |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frederick Henry lauber | Marie Agnes Haschert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James G. Lauber/Son | 1011 Wales Drive, LaPlata, MD 21158 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Dulaney Valley Mem. Grdns. | 8/24/01 | Timonium, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Bryan W. Clary | Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive heart failure | 2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Atherosclerotic Coronary artery disease | |
| | c. Due to (or as a consequence of): Hypertension | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Daniel Alexander | D0052815 | 8/20/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel Alexander, MD 200 Memorial Avenue, Westminster, MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-4823-015

JOE

McLEMORE

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27100

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Joseph W. McLemore

2. Date of Death Month / Day / Year: AUGUST 22, 2001

3. Time of Death: 5:55P.M.

4e. Facility Name *(If not institution, give street and number)*: ELKNECK STATE PARK

4b. City, Town, or Location of Death: NORTH EAST

4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 427-96-1201

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 27, 1951

9. Birthplaca *(State or Foreign Country)*: Summerall, MS

Usual Residence of Decedant

10a. Stata: New Jersey

10b. County: Salem County

10c. City, Town or Location: Corney's Point

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 265 E. Street

10f. Zip Coda: 08069

10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Naver Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heating & Air Conditioning

16b. Kind of Business/Industry: Heating & Air Conditioning

17. Fathar's Name *(First, Middle, Last)*: Lweis C. McLemore, Jr.

18. Mothar's Name *(First, Middle, Maiden Surname)*: Theo Rhodes

19a. Informant's Neme/Reletionship *(Type, Print)*: Mrs. Arlene McLemore(Wife)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 265 E. Street Corney's Point, New Jersey 08069

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: R.A. Ferris & Co. Inc. — Deta: 8/28/2001

20c. Location - City or Town, Steta: West Chester, PA.

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Neme and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HEAD INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last:

b.

Due to (or as a consequanca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No

24b. Ware autopsy findings availeble prior to completion of causa of death? 1 [X] Yas 2 [ ] No

25. Was casa rafarred to medical examiner? 1 [X] Yas 2 [ ] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residanca 6 [X] Othar *(Specify)* SCENE

27. Mannar of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigetion 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day, Year)*: 8/22/01 FOUND

28b. Tima of Injury: 1710 FOUND M

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describe how injury occurred: OPERATOR OF SCOOTER FELL OFF AND STRUCK PAVEMENT

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*: STATE PARK

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: SUSQUEHANNA LOOP ELKNECK STATE PARK, NORTH EAST, MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, daath occurred at tha time, date and placa, and due to the ceuse(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Data signed *(Month, Day, Year)*: AUGUST 23, 2001

30. Nama and address of parson who completed cause of death (Item 23e) (Type, Print): MARY A. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27101

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| ERNEST | EUGENE | MYERS | 08 | 18 | 2001 | UNKNOWN^M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1224 ELMLEAF COURT | BALTIMORE CITY | N/A |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-44-8560 | 1[X] M 2[ ] F | 55 Yrs. | | | | | MAR 24 1946 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1224 ELMLEAF COURT | 21202 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12yrs | | HEAVY EQUIP OPERATOR | B FRANK JOY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CALVIN THORNTON | ELLA MYERS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Diane M. Myers/ Wife | 1224 Elmleaf Ct., Baltimore, Maryland 21202 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | KING MEMORIAL PARK | 08-24-01 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PANCREATIC CANCER | 18 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE, HYPERTENSION

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown | 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | 047287 | AUGUST 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROL ANN HUFF, M.D. 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | [signature] Sparks |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27102

IRENE MATTHEWS
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| IRENE | EDNA | MATTHEWS | August | 20 | 2001 | 6:37 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Maryland General Hospital | Baltimore City | N/A |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 213-68-4511 | 1☐ M 2☒ F | 78 Yrs. | | | | | SEPT 19 1922 | VIRGINIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6000 BELLONA AVENUE | 21212 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unknown | | HOUSEWIFE | PRIVATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN MILES | unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carolyn E. Matthews/Daughter | 1009 Reverdy Rd., Baltimore, Maryland 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | KING MEMORIAL PARK | 8-25-01 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cerebrovascular Accident

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | 89398 | 08-20-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rashid Haq M.D. C/o Maryland General Hospital

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27103

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY McGEE
2. Date of Death Month Day Year: AUGUST 17 2001
3. Time of Death: 4:35 AM
4a. Facility Name (If not institution, give street and number): 3906 GRIERSON ROAD
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 213-38-7023
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 16, 1940
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3906 GRIERSON ROAD
10f. Zip Code: 21133
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 1 YR
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAB TECHNICIAN
16b. Kind of Business/Industry: SCIENTIFIC RESEARCH

17. Father's Name (First, Middle, Last): JOHN BENTON
18. Mother's Name (First, Middle, Maiden Surname): FRANCES SCOTT

19a. Informant's Name/Relationship (Type, Print): PATRICIA HENDERSON (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3906 GRIERSON ROAD, BALTIMORE, MD. 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): VOSHELL MEMORIAL GARDENS Date: 8-23-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung Cancer | 1 year |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Lung metastases; Malignant Hypercalcemia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D54911
29d. Date signed (Month, Day, Year): 08-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RODRIGO B. ERLICH 4940 EASTERN AVE. - BALTIMORE MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [signature] Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27104

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| IRENE MARTIN | | | AUGUST 20, 2001 | 1268P M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| ST AGNES HOSPITAL | BALTIMORE | | N/A | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-12-6173 | 1 M 2 X F | 76 Yrs. | | | MAR. 11, 1925 | PA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | N/A | BALTIMORE | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1501 N. DUKELAND ST. | 21216 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 X Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SECRETARY | OFFICE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| UNKNOWN | UNKNOWN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALICE COMM. ON AGING BELLAMY | 1000 CATHEDRAL ST. BALTO. MD. 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | HOLY TRINITY CEM. | AUG. 23 2001 | BALTO. MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Thomas J. Skarda Jr. | SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. INTESTINAL ISCHEMIA with SEPSIS | 8 days. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 X No 3 Probably 4 Unknown | 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD. | P14513 | AUGUST 20, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT A. BOVARD MD. 900 CATON AVE BALTIMORE MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Martin, Irene
Division of Vital Records, P.O. Box 68760,

6 2

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27105

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): David L. Matthews, Sr.

2. Date of Death: Month August Day 21 Year 2001

3. Time of Death: 02:35 AM

4a. Facility Name (If not institution, give street and number): VAMHCS FORT HOWARD DIVISION

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 417-01-7047

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 8, 1918

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2800 Kirkleigh Road

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): James A. Matthews

18. Mother's Name (First, Middle, Maiden Surname): Mary May Arnold

19a. Informant's Name/Relationship (Type, Print): Jeannie McCadden (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4452 Cole Farm Road Perry Hall, MD 21236

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gdns.

Date: 8/24/2001

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ADENOCARCINOMA OF RIGHT LUNG | 6 months |
| Due to (or as e consequence of): | | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. | MALIGNANT PLEURAL EFFUSION | 6 months |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: F. Lah, MD

29c. License number: 34359 (OH10)

29d. Date signed (Month, Day, Year): 8 21 '01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN LAH, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

MATTHEWS, DAVID L
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27106

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Florence | Maloney | | August 22 2001 | 9:16 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-09-1044 | 1☐ M 2☒ F | 83 Yrs. | | | May 7, 1918 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10e. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3411 McShane Way | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Detes: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Homemaker | Own Home |

| 17. Fether's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surneme) |
|---|---|
| James Michalak | Helen Marshakevicz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Thomas M. Maloney, Jr. (Son) | 7104 Eastbrook Ave. Baltimore, Maryland 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Sacred Ht. Jesus Cem. | 8/25/2001 | Dundalk, Maryland |

| 21. Signature of Funeral Servica Licensee | 22. Name and Address of Facility |
|---|---|
| Gregory E. Ruck | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Sepsis | 3 days |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last | Due to (or as a consequence of): | |
| | b. Due to (or es a consequenca of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Ascending aortic dissection, thoracic aortic aneurysm, acute renal failure, Stroke.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case relerred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Genevieve B. Melton-Meaux, MD | RES-000 | August 22, 2001 |

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Genevieve B. Melton-Meaux, 600 North Wolfe Street, Baltimore, Maryland 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | D Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27107

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| RICHARD MELLENDICK | 08 | 19 | 01 | 2245 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNIVERSITY MARYLAND MEDICAL CENTER | BALTIMORE. MD | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 219-18-5487 | 1 X M 2 F | 76 Yrs. | | | | | Jan. 9, 1925 | Louisiana |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Catonsville | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 425 Academy Road | 21228 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Technician | American Oil Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William F. Mellendick | Veronica McCurnin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Jane Mellendick Wife | 425 Academy RD. Catonsville, MD 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Garrison Forest | 8/23/2001 | Owings Mills, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward Schwab | Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave Catonsville, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cerebral vascular accident / stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atherosclerotic disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | AU417GH35T13156 | 08/19/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taledo 22 South Greene St, Baltimore, Md 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Geneva D Sparks |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-4786-005
mnmr
Christopher D. Marsh

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 090401:ITEMS#23a,27,28a-f per ME G799 SS

# Certificate of Death

Reg. No. 2001 27108

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CHRISTOPHER DEAN MARSH
2. Date of Death Month / Day / Year: August 20, 2001
3. Time of Death: 1650 pm

4a. Facility Name *(If not institution, give street and number)*: 7854 Harold Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-94-2933
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 21 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APR. 1, 1980
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7854 HAROLD ROAD
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11TH / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER ASSISTANT
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: TROY DEAN MARSH, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: SANDRA MARIE CLARY

19a. Informant's Name/Relationship *(Type, Print)*: SANDRA SHEETS/MOTHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 627 DELAWARE AVE., BALTIMORE, MD. 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SACRED HEART OF JESUS — Date: 8/24/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Elizabeth Selinski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: Found: 8-20-01
28b. Time of Injury: 4:45p M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Residence
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 7854 Harold Rd., Dundalk, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kingsmus
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING — 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001
32. Registrar's Signature: pp D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27109

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| BERNICE MAY MAJOR | AUGUST 23, 2001 | 4:10 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| EAST POINT NURSING CENTER | EAST POINT | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-01-2731 | 1☐ M 2☒ F | 82 Yrs. | | | 11/2/1918 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | PARKVILLE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8605 CHESTNUT OAK ROAD | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8TH GRADE | | CAFETERIA WORKER | MCCORMICKS |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| FRANK DULL | CLARE BRADLEY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOYCE JONES DAUGHTER | 8605 CHESTNUT OAK RD. BALTIMORE, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | MEADOWRIDGE MEM. PK. | 8/25/01 | ELKRIDGE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Heather N. Hay | THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | 2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Cerebrovascular Disease | 2 YRS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

| 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Matthew McNabney MD | D45757 | AUG 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW K McNABNEY 3505 HOPKINS BAYVIEW CIRCLE Balt 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

AMEND Item 12 State of Maryland / Department of Health and Mental Hygiene PER FH G798 08/27/0 RR

1- For State Registrar AMND ITM#26 PR. MD. G798 8-24-01 JAR

# Certificate of Death

Reg. No. 2001 27110

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner** — **Funeral Director** — **To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Woodrow | Newton | Aug. 16, 2001 | 2240p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Hospital | Baltimore | NA |

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 225-16-1134 | XX 1 M 2 F | 76 Yrs. | | | 01-13-25 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | XX 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2429 St. Paul Street 2nd.Floor | 21218 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 XX Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: X | 1 Yes 2 XX No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th Grade | NA | Roofer | Self-employed |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Fletcher Newton | Mary Frances |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 |
|---|---|
| Shirley Wright | 2429 St. Paul Street Baltimore, Maryland |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State XX 4 Donation 5 Other (Specify) | Garrison Forest VA Cem. | 08-27-01 | Owings Mills MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner** — **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arrhythemia — 1 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 XX ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]
29c. License number D45475
29d. Date signed (Month, Day, Year) 8/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Mohammad Rahnama, MD 6730 Holabird Avenue Dundalk, MD. 21222

**State Registrar**

31. Date filed (Month, Day, Year) AUG 24 2001
32. Registrar's Signature ▶ [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-4576-510

ALBERT
NAGEL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No.: 2001 27111

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Albert Nagle
2. Date of Death (Month, Day, Year): AUGUST 10, 2001
3. Time of Death: 4:34P.M.
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-46-4591
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3604 Mohawk Avenue
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Albert Nagel
18. Mother's Name (First, Middle, Maiden Surname): Shirley Day

19a. Informant's Name/Relationship (Type, Print): Doris Nagle/ Aunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5714 Newholme Ave. Baltimore MD 21206

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto/Wash Crematory
Date: 8/21/01
20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

**Physician /Medical Examiner**

23a. Part1. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Enviromental Hyperthermia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: psychiatric illness

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 08-10-2001
28b. Time of Injury: Found 1505 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject exposed to high enviromental temperature
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3604 Mohawk avenue Baltimore City, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Gene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #23, partII PER PHY G798 8/24/01 JH

Reg. No: 2001 27112

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| John | W. | Noel | August 19, 2001 | 1:00 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5925 Setter Drive | Elkridge | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-09-1950 | 1☒M 2☐F | 88 Yrs. | | | March 7, 1913 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Elkridge | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5925 Setter Drive | 21075 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Maintenance Engineer | Oil Burner Repair Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Sylvester Price Noel | Ella Valerie George |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ella Valerie Roberts/Daughter | 411 Highmeadow Road Reisterstown, Maryland 21136 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Memorial Park | 8/23/01 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Juanita R Thomas | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Non-small cell Lung Cancer | 2 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aspiration, chronic

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☒Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Paul Gormley MD | D18587 | August 21 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL GORMLEY 3350 Wilkens Ave Suite 110 Balto. MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Spates |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27113

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Walter L. Nowowieski

2. Date of Death Month: August Day: 21 Year: 2001

3. Time of Death: 10:00pm

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-05-5515

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July19,1914

9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: VA

10b. County: New Kent

10c. City, Town or Location: Quinton

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7301 Timber Ridge Road

10f. Zip Code: 23141

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Highs Food Store

17. Father's Name *(First, Middle, Last)*: Walter J. Nowowieski

18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Etmanski

19a. Informant's Neme/Relationship *(Type, Print)*: Phyillis Duval/daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 100 Beacon Point Court JoppatownMD 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Date: 8/25/01

20c. Location - City or Town, State: Rossville MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name end Address of Facility: ConnellyFuneralHomeofEssex 300 MAce Ave. Baltimore MD. 21221

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death) a. END STAGE DEMENTIA

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but nol rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death *(Chack only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and ptace, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 8/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

AUGUST 21, 2001 10 p.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WALTER NOWOWIESKI

01-4797-510
crn
Lyman Phillips

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27114

UNPENDED 011102:ITEMS#1,23a,27 per ME G803 ss

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lyman Phillips, Jr.

2. Date of Death: Month: August; Day: 16; Year: 2001

3. Time of Death: 1:59 P.M.

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-50-4405

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): 11/11/48

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 711 E. 43rd Street

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver

16b. Kind of Business/Industry: MTA

17. Father's Name (First, Middle, Last): Lyman Phillips, Sr.

18. Mother's Name (First, Middle, Maidan Surnama): Alice Williams

19a. Informant's Name/Relationship (Type, Print): Pastor Alice B. Phillips

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9707 Parkland Rd., Baltimore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forest Cem.

Data: 8/24/01

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funaral Service Licensee: ▶ Gladys Warner

22. Nama and Addrass of Fecility: March Funeral Home-East, 1101 E. North Ave., Balto. MD 21202

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA DUE TO CARDIOMEGALY AND CIRRHOSIS OF LIVER

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wayne DeHaven MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY DAVIS A. KOHORN, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: ▶ Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27115

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mildred G. Palardy
2. Data of Death — Month: Aug Day: 22 Year: 2001
3. Time of Death: 7:50 PM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 138-03-9956
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug 26, 1911
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town, or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1811 Coburg Ct.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): HARNER
18. Mother's Name (First, Middle, Maiden Surname): Stella Valentine

19a. Informant's Name/Relationship (Type, Print): Dennis P. Palardy, SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3610 Hallmark Ct. Parkville MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Dulaney Valley Mem Gardens — Date: 8-25-01
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: Baltimore MD 21234. EVANS Funeral Chapel 8800 HARFORD RD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

AUGUST 22, 2001 7:50 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

MILDRED GRACE PALARDY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sedonia Phillips
CJ
01-4802-510

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 090501:ITEMS#23a,27 per ME G799 SS

# Certificate of Death

Reg. No. 2001 27116

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| SEDONIA PHILLIPS | August | 21 | 2001 | 02:53 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Agnes Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-84-5716 | 1☐ M 2☒ F | 39 Yrs. | | | DEC 3, 1961 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1216 APPLE LEAF COURT | 21202 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: AFRICAN AMERICAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | 0- | LABORER | FACTORY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | EUGENIA HARRINGTON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| REGINALD PHILLIPS (BROTHER) | 2944 WINCHESTER STREET BALTIMORE, MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | WOODLAWN CEMETERY | 8/27/01 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LIVER CIRRHOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☑ Yes 2☐ No | 1☑ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. M. T. | O.C.M.E. | August 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ D. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27117

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emmett Henry Parker
2. Date of Death: Month August Day 19, Year 2001
3. Time of Death: 10:52 am
4a. Facility Name (If not institution, give street and number): 1 Brett Court, Apartment # 106
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-16-1725
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1, 1923
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1 Brett Court, Apartment # 106
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Clyde Parker
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Deans

19a. Informant's Name/Relationship (Type, Print): Bobbie Karcher (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 234 Brown Road, Fawngrove, Pennsylvania 17321

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Nat'l. Cemetery | Date: 8/20/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE Pulmonary Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E.P. Williamson MD
29c. License number: D 11171
29d. Date signed (Month, Day, Year): August 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.P. Williamson 3933 St. Johns Lane Ellicott City Maryland 21042

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: pervious B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27118

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM A. ROBINSON, JR
2. Date of Death Month Day Year: 08-23-2001
3. Time of Death: 9:55 M
4a. Facility Name (If not institution, give street and number): 6928 DIGBY ROAD
4b. City, Town, or Location of Death: GWYNN OAK
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 243-18-5365
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-07-1923
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: GWYNN OAK
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 6928 DIGBY ROAD
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+): 6 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: FREDRICK COUNTY

17. Father's Name (First, Middle, Last): WILLIAM A. ROBINSON, SR.
18. Mother's Name (First, Middle, Maiden Surname): LOUETTA ALEXANDER

19a. Informant's Name/Relationship (Type, Print): ANN C. ROBINSON | WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6928 DIGBY RD., BALTO. MD. 21207

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 8-30-2001
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC LUNG CA — 2 1/2 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D55398
29d. Date signed (Month, Day, Year): 8-24-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FLAVIO KRUTER MD 21 Crossroads Drive #415 Owings Mills MD 21117

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles Rosulac
CJ
01-4734-510

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMND ITM#1 PR. M.E. G798 8-24-01 JAB *Certificate of Death*

Reg. No. 2001 27119

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Charles | Roulac JR. | August | 17 | 2001 | 07:17 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-32-5664 | 1☒ M 2☐ F | 64 Yrs. | | | | | 07 05 37 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4009 Cedardale Road | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th grade | na | Auto Mechanic | Gas Station |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Roulac Sr. | Smithie Capehart |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Catherine Whitley-Sister | 4009 Cedardale Road, Baltimore Md 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Woodlawn Cemetery | 8/24/01 | Baltimore Co, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas B Lake | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Seizure Disorder complicating Chronic Alcoholism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Jack M. Titus, M.D. | O.C.M.E. | August 18, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Lawrence P Sparks |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#18 per fh G798 082401 SS

# Certificate of Death

Reg. No. 2001 27120

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ricka Ruth Robinson

2. Date of Death (Month, Day, Year): Aug 19 2001

3. Time of Death: 1:30 AM

4a. Facility Name (If not institution, give street and number): 1 Sharon Wood Court

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-72-6029

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/13/1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1 Sharon Wood Court

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Henry Hoos

18. Mother's Name (First, Middle, Meiden Surname): Annie Judith Brandau ~~Brandon~~

19a. Informant's Name/Relationship (Type, Print): Ruth Sansbury / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Sharon Wood Court Catonsville, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 8/22/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Bernard Dalmasso

22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Myeloma — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Goomesy MD

29c. License number: D18587

29d. Date signed (Month, Day, Year): Aug 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Goomesy 3350 Wilkens Ave Suite 100 Baltimore MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Jeanne M Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Q-10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amnd itm#24a&b PR. F.H. G798 8-24-01 JAB

# Certificate of Death

Reg. No. 2001 27121

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nijhae Jaylean Reaves
2. Date of Death Month: 5, Day: 22, Year: 2001
3. Time of Death: 1550 M
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE City

**Funeral Director**

5. Social Security Number: none
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min. 13
8. Date of Birth (Month, Day, Year): May 22, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 830 Newington Avenue #B
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
18b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): Jerry Reaves
18. Mother's Name (First, Middle, Maiden Surname): Nakeny P. Glenn

19a. Informant's Name/Relationship (Type, Print): UMMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. EXTREME PREMATURITY (PRE-VIABLE)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric Reynolds, M.D
29c. License number: D0055756
29d. Date signed (Month, Day, Year): 5/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC REYNOLDS UNIVERSITY OF MARYLAND, DEPT OF NEONATOLOGY, 22 S. GREENE ST, BALTIMORE MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Genevieve G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27122

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|
| FREDA | ROSENBERG | AUGUST 20 2001 | 6:02 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 10 COBBLER COURT | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-09-7339 | 1☐ M 2☒ F | 88 Yrs. | | | JULY 5 1913 | GA. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐ Yes 2☒ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10 COBBLER COURT | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HARRY GOLDBERG | ROSE KATZOFF |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ROSLYN ROSENBERG/DAUGHTER | 10 COBBLER COURT BALTIMORE, MD. 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | BALTIMORE HEBREW | 8/23/2001 | REISTERSTOWN, MD. |

21. Signature of Funeral Service Licensee: Michael Bruce

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. AORTIC STENOSIS | 2 YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CORONARY ARTERY DISEASE | 10 YRS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D19317 | 8/21/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BORIS KERZNER MD 1838 GREENSPRING DR STE 300, BALTIMORE, MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ D. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27123

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDDIE SMOTHERS
2. Date of Death (Month, Day, Year): AUGUST 17, 2001
3. Time of Death: 1520
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 230-28-0579
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 12 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-12-1929
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2556 W. FAIRMOUNT AVENUE
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE | College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): HARRY McELROY
18. Mother's Name (First, Middle, Maiden Surname): FLORENCE SMOTHERS

19a. Informant's Name/Relationship (Type, Print): BARBARA SMOTHERS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3922 RED DEER CIR, RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): METRO CREMATORY | Date: 8-21-01
20c. Location - City or Town, State: BALTO. MD. 21229

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: CREMATION SERVICES 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

**Physician /Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Chronic Endstage Emphysema | 5yrs. |
| Due to (or as a consequence of): b. | Mixed Sclerotic Cardiovascular Disease | 5yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Peripheral Vascular Disease | 5yrs. |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S Ramesh
29c. License number: D 30641
29d. Date signed (Month, Day, Year): August 21 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 3400 Erdman avenue Baltimore MD 21213

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: ▶ Genuine B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27124

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT M. SCHLOTT

2. Date of Death (Month, Day, Year): August 17, 2001

3. Time of Death: 9:07 p.m.

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-26-0196

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 3, 1931

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Finksburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 2525 Baltimore Blvd #13

10f. Zip Code: 21048

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter

16b. Kind of Business/Industry: self employed

17. Father's Name (First, Middle, Last): Walter Schlott

18. Mother's Name (First, Middle, Maiden Surname): Mildred Hostetter

19a. Informant's Name/Relationship (Type, Print): Mary Schlott/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2525 Baltimore Blvd #13 Finksburg, MD 21048

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cardiac arrest

Due to (or as a consequence of): b. myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. coronary artery disease

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: purulent vascular disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Boucheles MD

29c. License number: D 25127

29d. Date signed (Month, Day, Year): 8-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Boucheles 5601 Loch Raven Balt 21239

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Brenda D Sparks

Schlott, Robert

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27125

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: BONNIE MAE SHOWALTER
2. Date of Death Month Day Year: AUGUST 18, 2001
3. Time of Death: 7:05 PM
4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Hammond Lane
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 219-46-0199
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 21, 1946
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 613 Hammonds Lane
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 6
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: educator
16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: George Blaine Showalter
18. Mother's Name *(First, Middle, Maiden Surname)*: Freda Mae Drew

19a. Informant's Name/Relationship *(Type, Print)*: George Showalter/brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt Box 204 AA Andalusia, AL 36420

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or other place)*:
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Glioblastoma Multiforme
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Deep Vein Thrombosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*:
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D53462
29d. Date signed *(Month, Day, Year)*: 8/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Monteses MD 7845 Oakwood Road Glen Burnie, MD 21061

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001
32. Registrar's Signature: Sandra D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#4A PR. MD. G799 9-14-01 JAB

# Certificate of Death

Reg. No. 2001 27126

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Curley Ray Singletary
2. Date of Death (Month, Day, Year): Aug. 22, 2001
3. Time of Death: 4:00 AM
4a. Facility Name (If not institution, give street and number): 1233 Sugarwood ~~Road~~ CIRCLE
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 090-34-9112
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2, 1945
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1233 Sugarwood Circle
10f. Zip Code: 21221
10g. Citizen of What Country? USA.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Curtis Hyman
18. Mother's Name (First, Middle, Maiden Surname): Ophelia Goodman

19a. Informant's Name/Relationship (Type, Print): Stanley Singletary JR
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1233 Sugarwood Circle Essex Md 21221

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Vets. Cem
Date: 8/29/2001
20c. Location - City or Town, State: Garrison Md.
21. Signature of Funeral Service Licensee: Gloria Adams-Jones
Name and Address of Facility: Marshall & Jones, Jr. F.H. P.A. 401 Edmondson Ave. Balto. Md 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CANCER
Approximate Interval Between Onset and Death: 8 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G Cohen MD
29c. License number: D27730
29d. Date signed (Month, Day, Year): 8/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6519 N. CHARLES ST. BALTIMORE, MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4A
$
102

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27127

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VINCENT SIDOTTI

2. Date of Death — Month: August Day: 15 Year: 2001

3. Time of Death: 12:55AM

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 597-36-2776

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 17, 1930

9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: unk — 10b. County: unk — 10c. City, Town or Location: unk — 10d. Inside City Limits: unk (1☐ Yes 2☐ No)

10e. Street and Number: unk — 10f. Zip Code: unk — 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No: unk — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: unk

18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: Maryland General Hospital

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 827 Linden Avenue Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Non Small Cell lung Cancer Metastatic to Liver

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury M:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 89398

29d. Date signed *(Month, Day, Year)*: 08-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rashid Haq M.D. c/o Maryland General Hospital

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001

32. Registrar's Signature:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Sidotti Vincent
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMND ITM#1 PR. MD. G798 8-24-01 JAB

Reg. No. 2001 27128

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month / Day / Year) | 3. Time of Death |
|---|---|---|
| CORDIS STANFIELD STANFIELD CORDIS | August 17 2001 | 5:40am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8403 Charlton Road/Downes House Care | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-42-9323 | XXM 2☐F | 54 Yrs. | | | 09 04 46 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Pikesville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4643 Hawksbury Road | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 2 yrs | Electric Tech | Postal Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel Stanfield | Essie Blackwell |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cherly Banks-Ex-Wife | 4643 Hawksbury Road, Pikesville Md 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory Inc. | 8/23/2001 | Baltimore, Md |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: March F/H West, 4300 Wabash Avenue Balto, Md 21215

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. ? Sepsis | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. decubitus ulcer | |
| | Due to (or as a consequence of): | |
| | c. Muscular dystrophy. | |
| | Due to (or es e consequence of): | |
| | d. Hypertension. | |

Part II. **Other significant conditfone** contributing to death but not resulting in the underlying ceuse given in Part I.

bed ridden due to Muscular dystrophy.

23b. Did tobacco use contribute to the cauee of death? 1☐Yee 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) assisted living |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D 0055171 | 8/17/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3023 Eastern Avenue, Baltimore MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | [signature] |

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27129

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rose marie Smith
2. Date of Death (Month, Day, Year): August 18 2001
3. Time of Death: 0850 AM
4a. Facility Name (If not Institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 577-38-4197
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 19, 1919
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2313 MONTICELLO ROAD
10f. Zip Code: 21216
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): — College (1-4or 5+): 4 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN
16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): CHARLES WILLIE DAVIS
18. Mother's Name (First, Middle, Maiden Surname): LUCRETIA BUNCH

19a. Informant's Name/Relationship (Type, Print): ROSE SMITH (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2313 MONTICELLO RD. BALTO. MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): LOUDON PARK CEMETERY — Date: 8-24-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 1 hour
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D51426
29d. Date signed (Month, Day, Year): August 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Rothschild 40000 dd court Rd, Pikesville, MD 21208

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27130

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Marlin Sponaugle, Sr.
2. Date of Death: Month August Day 22 Year 2001
3. Time of Death: 5:45 AM
4a. Facility Name (If not institution, give street and number): 1740 Burnham Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-22-5031
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Houre / Min.
8. Date of Birth (Month, Day, Year): Oct. 26, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1740 Burnham Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steelworker
16b. Kind of Business/Industry: Hot Strip Mill

17. Father's Name (First, Middle, Last): Marlin Sponaugle
18. Mother's Name (First, Middle, Maiden Surname): Ada Leasure

19a. Informant's Name/Relationship (Type, Print): Mrs. Alma P. Sponaugle (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1740 Burnham Road Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 8/24/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Gregory E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cirrhosis of Liver — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roger Gorbaty MD
29c. License number: D27438
29d. Date signed (Month, Day, Year): 8/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Gorbaty MD 795 Aquahart Rd Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27131

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Kathryn W. Sunderland | Aug. 20, 2001 | 2:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 20 Enchanted Hills Road Apt. 1 | Owings Mills | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Yaar) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 214-12-1385 | 1☐M 2☒F | 80 Yrs. | | | Nov 8, 1920 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3939 Roland Avenue Apt. 501 | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - American Indian, Black, Whita, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married ☒Widowed 4☐Divorced | 1☐Yas ☒No If Yas, Giva Yaar or Dates: | 1☐Yas 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grada compliated) | | 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | School Assistant | Education Baltimore City 53 |
| 12 | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maiden Surname) |
|---|---|
| Earl Wagner | Margaret Foley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) |
|---|---|
| Judith Wilson Daughter | 20 Enchanted Hills Road Apt. 1 Owings Mills MD 21117 |

| 20a. Method of Disposition | 20b. Placa of Disposition (Name of cematery, crematory or othar placa) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Buriat 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify) | Woodlawn Cemetery | 8/23/01 | Woodlawn, Maryland |

21. Signature of Funeral Service Licensee ▶ Larry H Carpenter

22. Nama and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina.

| | | Approximate Interval Between Onsal and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | minutes |
| Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Dua to (or as a consequence of): | |
| | c. Dua to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? | 23c. If yas, outcoma of pregnancy | 23d. Date of dalivery Month Day Year |
|---|---|---|
| 1☐Yas 2☒No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to daath but not rasulting in the undarlying cause given in Part I.

Hodgkins Disease

23a. Did tobacco usa contributa to tha causa of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Ware autopsy findings available prior to compliation of cause of daath? |
|---|---|
| 1☐Yes 2☒No | 1☐Yas 2☒No |

| 25. Was case referred to medical examiner? | 26. Placa of Daath (Check only ona) | |
|---|---|---|
| 1☐Yas 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Home 5☐Rasidence 6☒Othar (Specify) DAUGHTERS HOME |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| ☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) | 28f. Location (Street and Numbar or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) ☒1 **Certifying Physician**: To tha best of my knowledga, death occurrad at tha time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha causa(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| ▶ Robin Owens | D23076 | 8-22-01 |

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): RICHARD L. DIAMOND, MD. 3730 FALLS RD. BALTIMORE MD 21211

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| AUG 24 2001 ▶ | Jeanne D Sparks |

DHMH 17 Rav 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27132

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Walter F. Shaffer
2. Date of Death Month Day Year: AUGUST 17, 2001
3. Time of Death: 11:35 PM
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 166-12-6218
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: April 16, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 1414 Burton Avenue
10f. Zip Coda: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowad 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yaar or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Groundskeeper
16b. Kind of Business/Industry: Helmore Farm

17. Father's Name *(First, Middle, Last)*: Walter Sheffer
18. Mother's Name *(First, Middle, Meiden Surnema)*: Myrtle Walker

19a. Informant's Neme/Relationship *(Type, Print)*: Ruth Shaffer Wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1414 Burton Avenue Lutherville, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Evergreen Mem. Gardens
Date: 8/23
20c. Location - City or Town, Stete: Finksburg, MD

21. Signature of Funeral Service Licensee: Tracy Henss Cagarte
22. Nama and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last:
b. Diabetes Mellitus
Due to (or es e consequence of):
c.
Dua to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Ware autopay findings availeble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examfner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signatura and title of certifiar: D Boersma MD
29c. License number: D40048
29d. Data signed *(Month, Dey, Year)*: 8-21-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DAVID BOERSMA 7505 OSCEOLA DR #510 TOWSON MD 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 24 2001
32. Registrar's Signature: Geneva B Sparks

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Shaffer, Walter F.

1 of 1

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #30 PER DVR G798 8/28/01 JH

# Certificate of Death

2001 27133
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| BERYL E SPOONER. | August 21 2001 | 4:45AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8411 Coco Road | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 015 36 7964 | 1☐M 2☒F | 97 Yrs. | | | October 22 1903 | Athol, MA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Rosedale | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8411 Coco Road | 21237 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | N/A | Homemaker | Housekeeping-Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ernest W. Haskins | Paulena Tatro |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard M Spooner (Son) | 8411 Coco Road Baltimore, Maryland 21237 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | South Cemetery | 8-24-01 | Orange, MA. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Matthew Joseph Chiocchi | Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Malnutrition | |
| Due to (or as a consequence of): | b. Alzheimer's Disease | 8 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D0028949 | 8/21/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANAYIOTIS A. BALTATZIS 1232 RACE RD. STE. 202 BALTO. MD. 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No: 2001 27134

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Tymeson

2. Date of Death (Month, Day, Year): August 22 2001

3. Time of Death: 11:30A M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-22-5460

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9829 Forge Park Road

10f. Zip Code: 21128

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William K. Pinkerton, II

18. Mother's Name (First, Middle, Maiden Surname): Florence Livingston

19a. Informant's Name/Relationship (Type, Print): John Mansperger, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6013 Mannington Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 8/25/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Multi-organ failure — 5days

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Ischemic Bowel — 2weeks

Due to (or as a consequence of):

c. Peripheral Vascular Disease — years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Deta of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis

Renal Failure

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause ot deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lewis Rubinson, MD

29c. License number: D56127

29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Lewis Rubinson 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Tymeson, Ruth
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-4801-033
crn
Calvin Bates Trotter

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27135

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Calvin Bates Trotter
2. Date of Death: Month: August Day: 21 Year: 2001
3. Time of Death: 9:45 A.M.
4a. Facility Name (If not institution, give street and number): 9010 Briarcroft Lane, #306
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 411-28-9618
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 21, 1924
9. Birthplace (State or Foreign Country): Tenn.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9010 Briarcroft Lane #306
10f. Zip Code: 20708
10g. Citizen of What Country: USA
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No WW2 If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Courier
16b. Kind of Business/Industry: American Security & Trus
17. Father's Name (First, Middle, Last): Tate Trotter, SR.
18. Mother's Name (First, Middle, Maiden Surname): Ida Lee Swann
19a. Informant's Name/Relationship (Type, Print): Patricia Boothe-daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13428 Rich Lynn Court, Highland, Md. 20777
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sharon Baptist Church Cemetery
Date: 08/28/01
20c. Location - City or Town, State: Powell, Tenn.
21. Signature of Funeral Service Licensee: ▶ Sandra L Lemmer
22. Name and Address of Facility: Witzke Funeral Home of Columbia, Inc. 5555 Twin Knolls Road, Columbia, Md. 21045

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact gunshot wound of chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Inspection 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): Found 08-21-2001

28b. Time of Injury: unknown M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9010 Briarcroft Prince Georges County, Maryland

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-4596-510
CJ
CAL ROLAND TINDAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.: 2001 27136

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CAL ROLAND TINDAL
2. Date of Death (Month, Day, Year): AUGUST 11 2001
3. Time of Death: 08:47AM
4a. Facility Name (If not institution, give street and number): 1923 WEST LAFAYETTE AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 247-82-9452
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-24-1947
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1923 WEST LAFAYETTE AVE
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: MURRY'S STEAK

17. Father's Name (First, Middle, Last): CALHOUN TINDAL
18. Mother's Name (First, Middle, Maiden Surname): GENEVA TINDAL

19a. Informant's Name/Relationship (Type, Print): DIANE STRAYHAM
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1923 W. LAFAYETTE AVE BALTIMORE MD 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST | Date: 21 AUG. 01
20c. Location - City or Town, State: OWINGS MILLS MD

21. Signature of Funeral Service Licensee: E.N.WALKER JR
22. Name and Address of Facility: ESTEP BROS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTIMORE MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Hemopericardium
Due to (or as a consequence of):
b. Ruptured Dissecting AORTA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HYPERTENSIVE Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J.M. Locke for
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.L. LOCKE, M.D. 111 PENN STREET, BALTIMORE MARYLAND 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-4808-005
B.K.S
PATRICIA TEAMS

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27137

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PATRICIA JACKSON TEAMS
2. Date of Death (Month, Day, Year): AUG. 21, 2001
3. Time of Death: 2:08 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: [illegible]
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-4-1954
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: NY
10b. County:
10c. City, Town or Location: NEWYORK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1839 LEXINGTON AVE.
10f. Zip Code: 10029
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify BLACK
15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOUSING ATTENDANT
16b. Kind of Business/Industry: N.Y.HOUSING
17. Father's Name (First, Middle, Last): HUBERT JACKSON
18. Mother's Neme (First, Middle, Meiden Surneme): SARAH JACKSON
19a. Informant's Neme/Reletionship (Type, Print): BETTY COLEMAN (SISTER)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3705 MOHAWK AVE. BALTIMORE MD 21215
20a. Method of Disposition: 1☒ Buriet 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): ROSEHILL CEMETERY
Date: 27AUG01
20c. Location - City or Town, Stete: LINDEN N.J.
21. Signature of Funeral Service Licensee: E.N.WALKER JR.
22. Neme end Address of Fecility: ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTIMORE MD 21217

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. (Approximate Interval Between Onset end Deeth)

Immediate Cause (Finel disease or condition resulting in deeth): a. Hypertensive atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Wes cese referred to medicat exeminer? 1☒ Yes 2☐ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUG. 22, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Dete filed (Month, Day, Year): AUG 24 2001
32. Registrer's Signeture: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27138

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Drew | Alexander | Upton | August | 22 | 2001 | 11:20 a.m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1524 Elwyn Avenue | Crofton | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 228-64-7722 | X 1 M 2 F | 54 Yrs. | | | | | March 15,1947 | Massachusetts |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Crofton | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1524 Elwyn Avenue | 21114 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Rece - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Merried 3 Widowed 4 Divorced | 1 Yes X No If Yes, Giva Yaar or Datas: | 1 Yes X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| | 5+ | CEO | Medical Devices |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Sumame) |
|---|---|
| Leslie Upton | Anne Spiegelman |

| 19e. Intormant's Neme/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Sharon F. Upton (Wife) | 1524 Elwyn Avenue, Crofton, MD 21114 |

| 20a. Method of Disposition | 20b. Place ot Disposition (Neme of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 X Burial 2 Cremetion 3 Removal from Stata 4 Donetion 5 Other (Specify) | Lakemont Memorial Gardens | 08/25 2001 | Davidsonville, MD |

| 21. Signature of Funeral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| ▶ [signature] | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. [illegible]

Due to (or as a consequence ot):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.

Due to (or es a consequence ot):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause ot death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place ot Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Dete of Injury (Month, Dey Year) | 28b. Time ot Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 8 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) |
|---|---|
| | |

29e. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

| 29b. Signeture and title of certifier | 29c. License number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D23743 | 8-24-01 |

30. Nama and address of person who completed cause ot deeth (Item 23e) (Type, Print)
MARTIN WELTZ 7525 Greenway Gr Dr. Greenbelt MD 20770

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] |

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27139

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| SOPHIE MARGARET VILLACIS | JUNE 26 2001 | 1:47 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NATIONAL NAVAL MEDICAL CENTER | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-61-0911 | 1☐M 2☒F | Yrs. | | | 6 JUNE 26, 2001 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8510 16TH STREET #415 | 20910 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | NEVER WORKED | NONE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH D. VILLACIS | ROSEMARIE ENNIS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOSEPH D. VILLACIS/ FATHER | 8510 16TH STREET #415 SILVER SPRING, MARYLAND 20910 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | MONTGOMERY CREMATORIUM INC. | AUGUST 22, 2001 | BETHESDA, MARYLAND |

21. Signature of Funeral Service Licensee ▶ [signature] M00335

22. Name and Address of Facility ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814-3501

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PREMATURITY
Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequenca of):
c. Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the causa of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☒Yes 2☐No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Colette M Hess D.O. | 02002120 (IN) | 6/28/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
COLETTE M. HESS, LT, MC, USN
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27140

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norman Thomas Wilson
2. Date of Death: Month 08 Day 21 Year 2001
3. Time of Death: 8:10 pM
4a. Facility Name (If not institution, give street and number): 401 Birdsong Ct.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 133-34-4840
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/13/43
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 401 Birdsong Ct.
10f. Zip Code: 21225
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editor
16b. Kind of Business/Industry: Baltimore Sunpaper

17. Father's Name (First, Middle, Last): Oscie Chester
18. Mother's Name (First, Middle, Maiden Surname): Estelle Wilson

19a. Informant's Name/Relationship (Type, Print): Michelle Williams
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Birdsong Ct., Balto. MD 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cem. Date: 8/27/2001
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warren
22. Name and Address of Facility: March Funeral Homes-East 1101 E. North Ave., Baltimore, MD 21202

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — Approximate Interval Between Onset and Death: YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: 015620
29d. Date signed (Month, Day, Year): 8/23/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARC S. POSNER MD 1147 S. HANOVER ST

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27141

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| ANNE | WILLIAMS | | August 22 2001 | 05 21 AM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| University of Maryland Medical Center | BALTIMORE | | BALTIMORE City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-26-3193 | 1☐M 2☒F | 79 Yrs. | | | JUNE 8, 1922 | NC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1556 MORELAND AVENUE | 21216 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: AFRICAN AMERICAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | 2 | NURSE | HEALTH CARE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CLEVELAND HOWARD | SUSIE HOWARD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| LINDA S. HUGHES (DAUGHTER) | 1556 MORELAND AVENUE BALTIMORE, MD 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | 8/23/01 | CATONSVILLE, MD |

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Intracranial Hemmorrhage | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Hypertension | |
| | Due to (or as e consequenca of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of Certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ 13693 | 13693 | 8/22/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Todd L. Stessinger MD, 22 South Greene St, Baltimore, MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Jeanne M Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27142

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roger Wehner

2. Date of Death: Month: August Day: 20 Year: 2001

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-66-2647

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/16/1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 96 Rolling Brook Way

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Golf Shop

17. Father's Name (First, Middle, Last): Gordon Jacob Wehner

18. Mother's Name (First, Middle, Maiden Surname): Florence Clara Hilton

19a. Informant's Name/Relationship (Type, Print): Michele Wehner wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 96 Rolling Brook Way Catonsville, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. View Cemetery

Date: 8/24/01

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Roman Palmarchi

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Respiratory Distress Syndrome | 2 weeks |
| Due to (or as a consequence of): | b. Pneumonia | 3 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Scleroderma

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD, Clinical Fellow

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack W. Wu, John Hopkins Hospital, 600 N. Wolfe Street, Baltimore City, MD 21231

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#26 perPHYG798 8/2 Certificate of Death

Reg. No. 2001 27143

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joyce Aileen Worsham | August 18, 2001 | 9:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Rosaboles Place Assisted Living | Pikesville | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-20-6744 | 1☐M 2☒F | 74 Yrs. | | | Sept.9, 1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Catonsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2109 Fernglen Way | 21228 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William C. Weber | Margaret Lindsay |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jill Worsham-Todd Daughter | 122 Harry Lane Apt E; Owings Mills, Maryland 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore National | 8/22/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] moo869 | Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Dehydration | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Poor feeding | |
| | Due to (or as a consequence of): | |
| | c. Alzeimer's Dementia | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Decubitus Ulcers
Urinary tract infection

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☒Other (Specify) Assisted Living |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D0035674 | August 20, 2001 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| Wanda J. Simmons-Clemmons MD | 2600 Liberty Hts Ave 2nd Floor Baltimore MD 21215 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #11 PER FH G798 8/27/01 — **Certificate of Death** — Reg. No. 2001 27144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Joy Williams
2. Date of Death (Month, Day, Year): August 17, 2001
3. Time of Death: 1:46 AM
4a. Facility Name (If not institution, give street and number): 1602 Gail Road Apt 1
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-56-4491
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/21/1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1602 Gail Road Apt 1
10f. Zip Code: 21221
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Peyton
18. Mother's Name (First, Middle, Maiden Surname): Josephine Barnes

19a. Informant's Name/Relationship (Type, Print): Leon James Peyton (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1539 Becklow Avenue Middle River, Maryland 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: Aug 22 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Leon F Bruzdzinski
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. VALVULAR HEART DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Philip Panzarella, MD
29c. License number: D 36643
29d. Date signed (Month, Day, Year): August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9105 Franklin Square Drive Suite 309 Rossville, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27145

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROSALIE CATHERINE WHITTAKER

2. Date of Death: Month AUGUST Day 21 Year 2001

3. Time of Death: 8:35 PM

4a. Facility Name (If not institution, give street and number): MANOR CARE -ROSSVILLE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-07-1665

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 22, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7511 Kenlea Avenue

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs. | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Name (First, Middle, Last): James Joseph Murphy

18. Mother's Name (First, Middle, Maiden Surname): Alma Weber

19a. Informant's Name/Relationship (Type, Print): James F. Whittaker (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9133 Avondale Rd. Baltimore, Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith CEm. Date: 8-25-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Pulmonary Fibrosis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D53462

29d. Date signed (Month, Day, Year): 8/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Muheses MD 7845 Oakwood Road Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001

32. Registrar's Signature: [signature] B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Mt Manor Care Rossville Balto. 215-07-1665 T.O.D. - 845 pm Rosalie Whittaker 215-B Dr. Muheses

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27146

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JACQUELINE ANTIONETTE ANDERSON

2. Date of Death (Month, Day, Year): AUGUST 11 2001

3. Time of Death: 8:30AM

4a. Facility Name (If not Institution, give street and number): Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 220-07-9002

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 12, 1916

9. Birthplace (State or Foreign Country): Illinois

Usuet Residenca of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 325 Fort Hoyle Road

10f. Zip Code: 21085

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: U.S. Government

17. Father's Neme (First, Middle, Last): Phillip J. Valenta

18. Mother's Name (First, Middle, Meiden Sumeme): Mandina (nmn) Duplancich

19a. Informant's Name/Relationship (Type, Print): Frederick L. Anderson - Son

19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2115 Oaklyn Drive, Fallston, Maryland 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca): Bel Air Memorial Gardens | Date: 8/14/01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Charles A. Enge

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Chronic Renal Failure | 6 months |
| Due to (or as a consequence of): b. | Hypertension | 20 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as e consequence of): c. | | |
| Due to (or es e consequence of): d. | | |

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of cartifier: ▶ MD

29c. License number: D34052

29d. Date signed (Month, Dey, Yeer): August 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

**State Registrar**

31. Date filed (Month, Dey, Yeer): AUG 14 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

Anderson, Jacqueline M

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27147

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOHN W. AYTCH | AUG. 8 2001 | 3:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ANNE ARUNDEL MEDICAL CENTER | ANNAPOLIS | ANNE ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-46-1769 | 1 X M 2 F | 55 Yrs. | | | SEPT. 1 1945 | MARYLAND |

Usual Residance of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | ANNAPOLIS | 1 X Yas 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 200 A BOXWOOD RD APT. 104 | 21403 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Raca - American Indian, Black, Whita, atc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yas 2 X No If Yas, Giva Yaar or Datas: | 1 Yas 2 X No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th | 0 | CUSTODIAN | ST. ANNS CHURCH |

| 17. Father's Nama (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maiden Surname) |
|---|---|
| HENRY HIGHE | JULIA AYTCH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JULIA AYTCH (MOTHER) | 200 A BOXWOOD RD. APT. 104 ANNAPOLIS, MD. 21403 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) | ANNAPOLIS MEMORIAL GARDENS | 8/14/01 | ANNAPOLIS, MD. |

| 21. Signatura of Funeral Service Licensaa | 22. Name and Address of Facility |
|---|---|
| Larry E. Reese #00483 | WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceuse on aach lina.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediata Cause (Final disease or condition rasulting in daath) | a. Pneumonia | 2 weeks |
| Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in daath) Last | b. Dua to (or as a consequence of): | |
| | c. Dua to (or as a consequence of): | |
| | d. Dua to (or as a consequance of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yas, outcoma of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1 Yas 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at tima of daath 5 Othar (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

End stage renal failure

| 23a. Did tobacco usa contributa to tha causa of daath? | 24a. Was an autopsy performed? | 24b. Wara autopsy findings available prior to compiation of cause of daath? |
|---|---|---|
| 1 Yes 2 X No 3 Probably 4 Unknown | 1 Yes 2 X No | 1 Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yas 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accidant 3 Suicida 4 Homicida 5 Panding investigation 6 Could not ba datarmined | | M | 1 Yas 2 No | |
| | 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) | | | 28f. Location (Street and Number or Rural Routa Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Cartifiar (Check only one) 1 X **Certifying Phyaician:** To tha bast of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha causa(s) and mannar stated.

| 29b. Signatura and Titla of cartifiar | 29c. Licensa number | 29d. Data signad (Month, Day, Year) |
|---|---|---|
| Sigurd Beck, MD | D 46052 | 8/8/01 |

30. Name and address of parson who complatad cause of daath (Item 23a) (Type, Print)
SIGURD BECK, MD 64 Franklin Street, Annapolis, MD

**State Registrar**

| 31. Data Filad (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| AUG 13 2001 | Penny B Sparks |

DHMH 17 Rav 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MCO

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27148

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Betty | Lamore | Broadwater | August 6 2001 | 11:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll County General Hospital | Westminster | Carroll |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 266-22-1628 | 1☐M 2☒F | 78 Yrs. | | | Jan. 11, 1923 | Maryland |

To Be Completed by Funeral Director

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Union Bridge | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 316 Thomas St. | 21791 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | seamstress | sewing factory |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| Maurice E. Gray | Pauline Johnson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| H. Burnell Broadwater-husband | 316 Thomas St., Union Bridge, MD 21791 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Paul's Luth. Cem. | 8/10/2001 | Uniontown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Catharine Q. Hartzler | Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD 21791 |

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. metastatic lung cancer | 4 mos. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): GI bleed | 2 days |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

| 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D40850 | August 7, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YVONNE OTTAVIANO 555 S. Center St. Westminster Md 21157

WJR 5

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | Geneva B Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27149

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Barbara Jane Bond
2. Date of Death (Month, Day, Year): August 9, 2001
3. Time of Death: 6:30 pm
4a. Facility Name (If not institution, give street and number): Westminster Nursing & Rehabilitative Ctr
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 218-40-7051
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 15, 1937
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1701 Emory Road
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): Benjamin Franklin Bond
18. Mother's Name (First, Middle, Maiden Surname): Catherine Dansberger

19a. Informant's Name/Relationship (Type, Print): Joe Jenkins, attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10751 Falls Road, Suite 256, Lutherville, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Emory UM Cemetery
Date: 8/13/2001
20c. Location - City or Town, State: Upperco, MD

21. Signature of Funeral Service Licensee: ▶ Steven Wilmer M00723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CVA | 1 mo |
| Due to (or as a consequence of): b. | Renal Failure | 3 yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | COPD | 50 yr |
| Due to (or as a consequence of): d. | Lung Failure | 1 yr |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John W. Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 8.10.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road Westminster, Md 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001
32. Registrar's Signature: ▶ Jenna B Sparks

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WR 4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No.- 2001 27150

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: REBA LUELLA COX

2. Date of Death Month: 8 Day: 11 Year: 2001

3. Time of Death: 3PM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 216-14-0649

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 5, 1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 910 Chesney Lane

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: U. S. Government

17. Father's Name *(First, Middle, Last)*: Melvin (nmn) Scarborough

18. Mother's Neme *(First, Middle, Maiden Surname)*: Bessie Elenora Kelly

19a. Informant's Name/Relationship *(Type, Print)*: Dennis Scarborough - Brother

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1009 James Street, Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Bel Air Memorial Gardens

Date: 8/16/01

20c. Location - City or Town, Stete: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Neme end Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or liver failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Aspiration Pneumonia — 1 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or es e consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Dementia

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.

29c. License number: D34052

29d. Date signed *(Month, Day, Year)*: August 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 14 2001

32. Registrar's Signeture: Geneva B Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

DHMH 16 Rev 6/95

ORIGINAL

01-4582-025
jbm
KENNETH EDWARD
CONNER

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27151

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| KENNETH EDWARD CONNOR | AUGUST 10, 2001 | 05:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARFORD MEMORIAL HOSPITAL | HAVRE DE GRACE | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-54-6155 | [X] M 2 [ ] F | 52 Yrs. | | | Apr. 25, 1949 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Havre de Grace | [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 431 Brian Garth | 21078 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, spacify Cuban, Maxicen, Puarto Rican, etc.) | 14. Race - Americen Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highast grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Quality Reviewer | Telecommunications |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alfred (nmn) Connor | Florence (nmn) Guess |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Linda L. Connor - Wife | 431 Brian Garth, Havre de Grace, MD 21078 |

| 20a. Method of Disposition | 20b. Place of Disposition (Nama of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Hilltop Service Corp. | 8/17/01 | Towson, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility: McComas Funeral Home, P.A., 1317 Cokesbury Rd., Abingdon, MD 21009

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple injuries | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Causa (Disease or injury thet initiated avents resulting in deeth) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Wes cese referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined | 08-10-2001 | 1639 M | 1 [ ] Yes 2 [X] No | subject was driver of motor vehicle involved in a collision |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rurel Route Number, City or Town, State) |
| | Highway bridge | | | Route 40, Hatem Bridge Harford County, Maryland |

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

| 29b. Signeture and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ Stephen S. Nardetz, M.D. | OCME | AUGUST 11, 2001 |

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | ▶ [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27152

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNA (NMN) CAMPANARO

2. Date of Death: Month August Day 11, Year 2001

3. Time of Death: 6:05 A.M.

4a. Facility Name (If not institution, give street and number): 1302-K Scottsdale Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 053-12-5015

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 8, 1922

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1302-K Scottsdale Drive

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Emilio (nmn) Vignapiana

18. Mother's Name (First, Middle, Maiden Surname): Lucia (nmn) Giordano

19a. Informant's Name/Relationship (Type, Print): Mario V. Campanaro - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302-K Scottsdale Drive, Bel Air, MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Ignatius Cemetery

Date: 8/14/01

20c. Location - City or Town, State: Hickory, Maryland

21. Signature of Funeral Service Licensee: Kelly McComas Pennington

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway, Bel Air, MD 21014

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Sepsis | 3 days |
| Due to (or as a consequence of): b. | Gangrene | 1 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | Systemic Lupus Erythematosis | 10 years |
| Due to (or as a consequence of): d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature], DO, FACP

29c. License number: H34022

29d. Date signed (Month, Day, Year): August 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Lolasti, DO 1305 Business Center Way Edgewood, MD 21040

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

jm

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27153

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emlet Arvin Cronise
2. Date of Death (Month, Day, Year): July 31 2001
3. Time of Death: 12:15 AM
4a. Facility Name (If not institution, give street and number): Dulaney-Towson Health Care Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-18-2373
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 5, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2913 Knoll Acres Dr.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinist
16b. Kind of Business/Industry: can company

17. Father's Name (First, Middle, Last): Paul Thurston Cronise
18. Mother's Name (First, Middle, Maiden Surname): Anna Mary Haines

19a. Informant's Name/Relationship (Type, Print): K. Eugene Cronise - brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2913 Knoll Acres Dr., Baltimore, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Kriders Cemetery
Date: 8/3/01
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: ▶ Donnie L. Brother
22. Name and Address of Facility: Hartzler Funeral Home, 310 Church St., New Windsor, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 2 weeks |
| Due to (or as a consequence of): | b. Pneumonia | 2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): July 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): X/AO 21404 3007 E. Northern Parkway Baltimore 21042

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: ▶ Donna A Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Arvin Cronise

WJL 8

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27154

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| PHILLIP BRADFORD CRAWMER | AUGUST 8th 2001 | 9:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CARROLL COUNTY GENERAL HOSPITAL | WESTMINSTER | CARROLL. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-14-5558 | 1[X] M 2[ ] F | 82 Yrs. | | | 1/17/1919 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | CARROLL | WESTMINSTER | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 47 S. CHURCH ST. | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | SUPPLY MANAGER | PHONE CO. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| J. HERBERT CRAWMER | CORINE DUVALL |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BARBARA PEARL - FRIEND | 47 S. CHURCH ST., WESTMINSTER, MD. 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | WESTMINSTER CEMETERY | 8/11/01 | WESTMINSTER, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[X] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[X] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

26. Place of Death (Check only one)
Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA
Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1[ ] Yes 2[ ] No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D51596 | AUGUST 8th 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K. AMBALAVANAR, CAROLL COUNTY GENERAL HOSPITAL, 200 MEMORIAL AVE, WESTMINSTER MD 21157

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 30

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27155

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Montgomery Dorsey
2. Date of Death: Month 08 Day 06 Year 01
3. Time of Death: 6:28 a M
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER,
4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 218-05-1759
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 9, 1917
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 104 BOND STREET
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SADDLERY SALESMAN
16b. Kind of Business/Industry: horses

17. Father's Name (First, Middle, Last): BENJAMIN DORSEY
18. Mother's Name (First, Middle, Maiden Surname): ESTELLA STAUP

19a. Informant's Name/Relationship (Type, Print): WIFE MARIETTA POOL DORSEY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21157 104 BOND STREET WESTMINSTER, MD

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CARROLL CREMATORY
Date: Aug 9, 2001
20c. Location - City or Town, State: HAMPSTEAD, MD.

21. Signature of Funeral Service Licensee: Robert A. Myers
22. Name and Address of Facility: MYERS FUNERAL HOME 91 Willis St 21157 WESTMINSTER, MD.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Septic Shock
Due to (or as a consequence of): b. Peritonitis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Norman Goldstein
29c. License number: D26385
29d. Date signed (Month, Day, Year): 08 08 01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Norman Goldstein 218 Washington Heights Medical Center Westminster MD. 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: Geneva B Sparks

WJL 8

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27156

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): AUDREY TRAVERS DUCKWORTH
2. Date of Death (Month, Day, Year): AUGUST 7, 2001
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): SNOW HILL NURSING AND REHAB. CENTER
4b. City, Town, or Location of Death: SNOW HILL
4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 218-34-7754
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 16, 1927
9. Birthplace (State or Foreign Country): ENGLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 300 LEMMON HILL LANE
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: PUBLIC SCHOOLS
17. Father's Name (First, Middle, Last): DAVID EDWIN BULLER TRAVERS
18. Mother's Name (First, Middle, Maiden Surname): EDITH MAUDE COOKNEY
19a. Informant's Name/Relationship (Type, Print): DALE E. WATSON - PERS. REP.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 906 EASTERN SHORE DR. SALISBURY MD 21804
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CREMATORY OF DELMARVA
Date: 8-9-01
20c. Location - City or Town, State: DELMAR, DELAWARE
21. Signature of Funeral Service Licensee: B. Keyt CFSP
22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Pulm. Edema
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Renal Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pulm. Eff.; Biliary Stones; D.V.T.; Renal Failure; Dementia Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sarad
29c. License number: D54422
29d. Date signed (Month, Day, Year): 8-8-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SARAD BARAL, M.D. 500 MARKET ST. SUITE 103 POCOMOKE CITY, MD 21851

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: Donna G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27157

Rplacement SEE NOTE

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month | Day | Year | 3. Tima of Death |
|---|---|---|---|---|
| Louise Downs | July | 15 | 2001 | 12:50p.m. |

| 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Prince George's Medical Center | Cheverly | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 577-20-8525 | 1☐ M 2☒ F | 79 Yrs. | | | | | June 24, 1922 | Washington, D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Prince George's | New Carrollton | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5707 83rd Place | 20784 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yas, Giva Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Information Specialist | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Sumama) |
|---|---|
| Adrian L. Barriere | Gertrude G. Jennings |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joyce C. Herren - Daughter | 5707 83rd Place, New Carrollton, MD 20784 |

| 20a. Mathod of Disposition | 20b. Placa of Disposition (Name of cemetery, crematory or othar place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Fort Lincoln Cemetery | 7/19/2001 | Brentwood, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart-failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediata Causa (Final disease or condition resulting in death) | a. Malignant Arrythmia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Artery Disease | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bladder Carcimona

Cerebrovascular Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Routa Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the tima, date and placa, and due to the cause(s) and manner es stated.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D53850 | July 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven J. Schwartz, M.D., 3001 Hospital Drive, Cheverly, MD 20785

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 06 2001 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

8/24/01 Original death Certificate dated 7/18/01 was shredded by PG County Health Dept. Replacement Certficate created by PG County Health Dept without authorization ? copy of first original in voided file

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27158

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Dorothy | Elizabeth | Eyler | August 8 2001 | 12:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Glade Valley Nursing & Rehab Center | Walkersville | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-28-7978 | 1☐M 2☒F | 71 Yrs. | | | Sept. 12, 1929 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Carroll | Westminster | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 490 Tremont Dr. | 21157 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard Willard White | Naomi Grace Lewis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Faye E. Repass - daughter | 857 Starr Ct., Union Bridge, MD 21791 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Resthaven Mem. Gardens | 8/11/01 | Frederick, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donald L. Brothers | Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD 21791 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CHRONIC MYELOGENOUS LEUKEMIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

HTN

SEIZURE D/O

| 23a. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☒Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M Casagrande MD | D53224 | 8/8/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Casagrande MD 1564 Opossumtown Pike, Frederick 21702

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ Donna D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WJR 2

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27159

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Deta of Death Month Day Yaer | 3. Time of Death |
|---|---|---|---|
| AILEEN | FLATER | AUG. 7, 2001 | 7:45 AM |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1536 OLD WESTMINSTER PIKE | WESTMINSTER | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Aga (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-20-4463 | 1☐ M 2☒ F | 73 Yrs. | | | 11/12/1927 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | CARROLL | WESTMINSTER | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1536 OLD WESTMINSTER PIKE | 21157 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) | 14. Race - Americen Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | t6b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | MANAGER | FOOD SERVICE |

| 17. Fathar's Nama (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| WILLIAM CLINTON CAPLES | CATHERINE SMITH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21157 |
|---|---|
| SAMUEL FLATER -HUSBAND | 1536 OLD WESTMINSTER PIKE, WESTMINSTER, MD. |

| 20a. Method of Disposition | 20b. Ptace of Disposition (Neme of cemetery, cremetory or othar piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify) | SANDYMOUNT CEMETERY | 8/11/01 | SANDYMOUNT, MD. |

| 21. Signature of Funeral Service Licensee | 22. Nama end Address of Facility |
|---|---|
| ▶ R Lacy Fletcher | FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onsat and Death |
|---|---|---|
| Immediate Cause (Final diseese or condition resulting in deeth) | a. Generalised Carcinomatosis | 3 weeks |
| Due to (or as a consequenca of): | | |
| Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury thet initiated evants resulting in death) Last | b. Metastatic small cell lung cancer | 2 months |
| Due to (or as a consequenca of): | | |
| | c. | |
| Dua to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yea 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yea 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined | | | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) |

29a. Certifier (Check only one)
☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and ptaca, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D 45274 | 8/9/01 |

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)
Cleo Maury, MD 555 Center St. Westminster, MD 2157

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ Geneva B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27160

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HELEN M. FIGGS

2. Date of Death: Month AUGUST Day 7 Year 2001

3. Time of Death: 1142

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 222-12-5371

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-06-1926

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Seaford

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 27129 Woodland Rd

10f. Zip Code: 19973

10g. Citizen of What Country: US

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yaa or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Businass/Industry: Electric

17. Father's Nama (First, Middla, Last): William Passwaters

18. Mother's Name (First, Middle, Maidan Surnama): Sallie Marker

19a. Informant's Name/Relationship (Type, Print): Evelyn Harrold - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27129 Woodland Rd, Seaford, DE 19973

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Capitol Crematory | Date: 08/10/2001

20c. Location - City or Town, State: Dover, DE

21. Signature of Funeral Service Licensee: John A. Cranston

22. Name and Address of Facility: Cranston Funeral Home, P O Box 967, Seaford, DE 19973

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Mitral regurgitation | 12 years |
| Due to (or as a consequence of): b. | Recurrent ASCAD | 6mo |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c. | Chronic Atrial Fibrillation | |
| Due to (or as a consequence of): d. | Hypertension | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve replacement and coronary artery bypass Aug 6, 2001

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A. Buchness MD

29c. Licensa number: 02038

29d. Date signed (Month, Day, Year): 8/8/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): M. Buchness MD 201 Pine Bluff Rd Suite25 Salisbury MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

222 12 5371

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HELEN FIGGS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27161

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Sandra Mae Fitzgerald | August 11, 2001 | 4:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 334-30-5762 | 1☐M 2☒F | 63 Yrs. | | | Jan. 3, 1938 | Illinois |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 908 Primrose Rd. | 21403 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | Counselor | Public Health |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clyde J. Westgate | Viola Peronteau |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gail Westgate / Sister | 2338 Marshall Ave. #304 St. Paul, MN 55104 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore Crematory | 8/14/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael J. Sloan | John M. Taylor Funeral Home, Inc- 147 Duke of Gloucester St. Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Bowel Obstruction with Gangrene | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ira Weinstein MD | D38445 | Aug 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ira Weinstein 600 Ridgely Ave Annapolis MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | Donna P Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

RKD

01-4448-510

PETER

GETZ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27162

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Peter N. Getz

2. Date of Death: Month AUGUST Day 5 Year 2001

3. Time of Death: 9:17P.M.

4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 185-28-4590

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 25, 1933

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: PA

10b. County: York

10c. City, Town or Location: New Freedom

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 343 Constitution Ave.

10f. Zip Code: 17349

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Laborer

16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Francis Lee Getz

18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Mays

19a. Informant's Name/Relationship (Type, Print): Susan K. Grimek (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 144 N. Findley St., York, PA 17402

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Yorktowne Caskets, Inc. Cremation Service

Date: Aug. 8, 2001

20c. Location - City or Town, State: York, PA

21. Signature of Funeral Service Licensee: J.J. Hartenstein

22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 8/5/01

28b. Time of Injury: 1822 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Bicyclist struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): HARRIS MILL I-83

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): AUGUST 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-4471-013
crn
Jason Clifton Gloyd

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27163

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jason Clifton Gloyd
2. Date of Death: Month August Day 06 Year 2001
3. Time of Death: 9:45 A.M.
4a. Facility Name (If not institution, give street and number): Route 194 north of Reifsnider Road
4b. City, Town, or Location of Death: Taneytown
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 213-15-1486
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 27 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 17, 1974
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 94 Grand Drive
10f. Zip Code: 21787
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): lineman
16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): LeRoy Gloyd
18. Mother's Name (First, Middle, Maiden Surname): F. Marlene Bolyard

19a. Informant's Name/Relationship (Type, Print): Valtrina Gloyd/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 94 Grand Dr. Taneytown, MD 21787

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fairmount Cemetery
Date: 8/10/01
20c. Location - City or Town, State: Libertytown, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 8/6/01
28b. Time of Injury: 7:05 AM
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: DRIVER involved in auto accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): ROUTE 194 TANEYTOWN, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Titus
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 07, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 09 2001
32. Registrar's Signature: Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WJL 4

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27164

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARY GRAZIANI | August 8 2001 | 01:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Continuum Care | Sykesville | Carroll |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-36-1354 | 1☐ M 2☒ F | 98 Yrs. | | | Feb 27, 1903 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Granite | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10724 Davis Ave. | 21163 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th | | Laundry Operator | Woodstock College |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Evaristo Graziani | Catherine Zavirugha |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rita Weslow (sister) | 10724 Davis Ave. Granite, MD 21163 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | St. Alphonsus Cem. | 8/10/2001 | Woodstock, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CONGESTIVE HEART FAILURE | ~ 1 WEEK |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. AORTIC STENOSIS | >15 YRS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other **significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, TYPE 2

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] ATTENDING | D 40390 | August 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. A. DESAI, MD; 23 CROSSROADS DR. #325, OWINGS MILLS, MD 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

CEW 6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#20b perFHG798 *Certificate of Death* 8/31/01 EW Reg. No. 2001 27165

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lena Virginia Heatley | August 6, 2001 | 5:25 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Salisbury Rehab & Nursing Ctr. | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 221-20-1153 | 1☐M 2☒F | 90 Yrs. | | | June 1 1911 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Somerset | Eden | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 30766 Eden Allen Road | 21822 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Domestic | None |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Wesley Coulbourn | Minnie Dickerson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sheila Washington (Grandaughter) | 30766 Eden Allen Rd.Eden,Md.21822 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Springhill Mem.Garden | 8/11/01 | Hebron,Md. |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. coronary artery disease | yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): carotid stenosis | yrs. |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | 029849 | 8/21/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William H. Robins, M.D. 1104 Healthway Dr., Salisbury MD 21804

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Lena Heatley
Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

28 Days
5 MP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27166

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ROYSTON L. HARRISON | August 11, 2001 | 2:15AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Yeer) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-05-1160 | 1☒M 2☐F | 91 Yrs. | | | Sept. 01, 1909 | Maryland |

**To Be Completed by Funeral Director**

Usuel Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Florida | Marion | Ocala | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| Oak Run 8966 SW 115th Street | 34481-5042 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Detes: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grede completed) | | 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Type Setter | Newspaper |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| William Henry Harrison | Sadie Rose Tall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Wyvona M. Harrison (wife) | Oak Run 8966 SW 115th St. Ocala Florida 34481-5042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Glen Haven Cemetery | 8/18/2001 | Severna Park, Maryland |

| 21. Signafura of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Beverly M. Baker | John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode ot dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lung cancer | 1 mos. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. Due to (or as e consequence of): | |
| | c. Due to (or es a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time ot death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23e. Did tobacco use contributa to the causa ot death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yas 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Deeth | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurrad at tha time, data and place, and due to tha cause(s) and manner stated.

| 29b. Signeture and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| J. Selonich, MD | D19838 | 8/11/2001 |

30. Name and address ot person who completed cause of death (Item 23a) (Type, Print)
Stuart E. Selonich, MD 900 Bestgate Annapolis, Md. 21401

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

8/11/01 BAS 9/4

Roy Ton HARRISON 214-05-1160

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27167

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wain E Jones

2. Date of Death: Month 8 Day 5 Year 2001

3. Time of Death: 0140 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 216-56-0061

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 16, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Quantico

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 22377 Royal Oak Road

10f. Zip Code: 21856

10g. Citizen of What Country? U.S. of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Minister

16b. Kind of Business/Industry: Religous Ministry

17. Father's Name (First, Middle, Last): unknown Lawrence Hitchins

18. Mother's Name (First, Middle, Maiden Surname): Helen Green

19a. Informant's Name/Relationship (Type, Print): Cynthia L Jones wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22377 Royal Oak Rd Quantico MD 21856

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St James Free Methodist Church Cemetery

Date: August 11, 2001

20c. Location - City or Town, State: Quantico MD 21856

21. Signature of Funeral Service Licensee: Donna A Mars

22. Name and Address of Facility: Lewis N Watson Funeral Home 1618 West Rd Ext, Salisbury MD 21801

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. Coronary Artery Disease — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnency: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End - Stage Renal Failure
Failed Kidney transplant
Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Tan MD

29c. License number: 16725

29d. Date signed (Month, Day, Year): 8/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tan, Constante 542-G Riverside Drive Salisbury, MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001

32. Registrar's Signature: Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wain Jones 216 56 0061 8/5/01 0140

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27168

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kenneth Lawrence Johnson
2. Date of Death (Month, Day, Year): August 7, 2001
3. Time of Death: 8:40 AM
4a. Facility Name (If not institution, give street and number): 300 S. Bay Street
4b. City, Town, or Location of Death: Snow Hill
4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 217-90-1634
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 33 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 4, 1968
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 300 S. Bay Street
10f. Zip Code: 21863
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1991-93
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Lawrence Johnson
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Pennewell Johnson

19a. Informant's Name/Relationship (Type, Print): Elizabeth Johnson (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 S. Bay Street Snow Hill, MD 21863

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): First Baptist Cemetery — Date: Aug. 10, 2001
20c. Location - City or Town, State: Pocomoke, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Short Funeral Home, 13 E. Grove St. Delmar, DE 19940

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS — FEW YEARS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Holzworth M.D.
29c. License number: D 06741
29d. Date signed (Month, Day, Year): 8-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH M.D. 203 SNOW ST. SNOW HILL MD. 21863

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3 mp
IVA

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 27169
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): David Lane
2. Date of Death Month Day Year: AUG. 7 2001
3. Time of Death: 9:05 pm
4a. Facility Name (If not institution, give street and number): HCR MANOR CARE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 213-32-1085
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 31 1935
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: LAUREL
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 11304 LAUREL WALK DRIVE
10f. Zip Code: 20708
10g. Citizen of What Country? USA

11. Marital Stetus: 1 ☐ Never Merried 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detes:
13. Wes Decedant of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 12th
College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa retired): BRICKLAYER
16b. Kind of Business/Industry: MASONARY

17. Fethar's Neme (First, Middla, Last): JOHN LANE
18. Mothar's Name (First, Middle, Maiden Surneme): CLARA NELSON

19a. Informent's Neme/Reletionship (Type, Print): LISA A. LANE TREADWELL (DAUGHTER)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11733 BROOKVILLE LANDING CT. MITCHELLVILLE, MARYLAND 20721

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, crematory or other place): ANNAPOLIS MEMORIAL GARDENS
Data: 8/10/01
20c. Locetion - City or Town, Stete: ANNAPOLIS, MD.

21. Signeture of Funaral Service Licensee: Larry D. Reese M00483
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

**Physician /Medical Examiner**

23e. Part1. Enter thediseese, or complicetions that caused the death. Do not anter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immedlete Cause (Finel disaase or condition resulting in death)
a. Lung Cancer & Metastasis

Due to (or es a consequence of):
b. Hepatobiliary obstruction & catheter

Sequentlelly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted avents resulting in deeth) Lest
Due to (or es e consequence of):
c. Bacteremia & MRSA drainage.

Dua to (or es e consequence of):
d. Malnutrition

Part ii. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert i.

23b. **Did tobacco uee contribute to the cause of deeth?** 1 ☐ Yee 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings eveilabia prior to completion of cause of deeth? 1 ☐ Yas 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one)
Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify)

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2 ☐ **Medical Examinar**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Kirti Vohra M.D
29c. License number: D-20274
29d. Dete signed (Month, Dey, Yeer): 8/7/01

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print): KIRTI VOHRA M.D 7710 BRADLEY BLVD BETHESDA, MD 20817

**State Registrar**

31. Dete filed (Month, Day, Yaer): AUG 13 2001
32. Registrer's Signeture: Jenna G Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

mca

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27170

MONKS, JANE

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| JANE | VIOLA | MONKS | AUGUST 10, 2001 | 2:25 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-20-5575 | 1☐M 2☒F | 78 Yrs. | | | Mar. 14, 1923 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Harford | Aberdeen | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizan of What Country? |
|---|---|---|
| 2005 Park Beach Drive | 21001 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Raca - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yas 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grada completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Telephone Operator | Communications |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Name (First, Middle, Maidan Surname) |
|---|---|
| Edward (nmn) Kelly | Minnie (nmn) Belt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wheeler S. Monks - Husband | 2005 Park Beach Drive, Aberdeen, MD 21001 |

| 20a. Mathod of Disposition | 20b. Placa of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 8/14/01 | Towson, Maryland |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

jm

23a. Part I. Enter the disease, or complications that caused the daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

| | | Approximata Intarval Batwean Onset and Daath |
|---|---|---|
| Immediata Causa (Final disease or condition resulting in death) a. | ADULT RESPIRATORY DISTRESS SYNDROME | 2 WEEKS |
| Due to (or as a consequence of): b. | PERFORATED SIGMOID DIVERTICULUM | 2 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY FIBROSIS

RHEUMATOID ARTHRITIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residanca 8☐Othar (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not ba determined | | M | 1☐Yas 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Numbar, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To tha bast of my knowledga, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurrad at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Bruce Rosenberg MD | D24121 | 8/11/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE ROSENBERG 21 WEST RD TOWSON, MD 21204

15

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27171

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Karol | Paul | Mohr | August 7 2001 | 1100 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| The Johns Hopkins Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (If yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 174-26-5269 | 1 [X] M 2 [ ] F | 80 Yrs. | | | April 2, 1921 | Yugoslavia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Delmar | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 31275 East Line Road | 21875 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | — | Farmer | Agriculture |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Francis Mohr | Maria Volbert |

| 19a. Informent's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anna Mohr/Wife | 31275 E. Line Rd., Delmar, MD 21875 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Springhill Memory Gardens | 8/10/01 | Hebron, MD |

| 21. Signeture of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Keith R Dewey CFSP | Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 |

**Physician /Medical Examiner**

23e. Part I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in deeth) a. | sub-arachnoid hemorrhage | 2 months |
| Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last — Due to (or as e consequence of): b. | intracranial aneurysm | 2 months |
| Due to (or es a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant et time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

| 24a. Was en eutopsy performed? | 24b. Were eutopsy findings available pnor to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Wes cese referred to medical exeminer? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es steted.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ H. Christopher Lawson, MD | RES-000 | August 7, 2001 |

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
H. Christopher Lawson, MD 600 N. Wolfe St. Baltimore, MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 09 2001 | ▶ Jessica G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Medical Certification:**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27172

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| DORIS | HARRIET | MILLER | AUGUST | 7 | 2001 | 0010 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ATLANTIC GENERAL HOSPITAL | BERLIN | WORCESTER |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 003-16-7584 | 1☐M 2☒F | 70 Yrs. | | | | | NOV. 14, 1930 | NEW HAMPSHIRE |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| DELAWARE | SUSSEX | SELBYVILLE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 125 SHADY PARK | 19975 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | REGISTERED NURSE | HEALTH CARE |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| HAROLD | HOWE | GILBERTE | FILAULTE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JILL M. MACKIN/DAUGHTER | 125 SHADY PARK, SELBYVILLE, DE. 19975 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | CREMATORY OF DELMARVA | 8/9/01 | DELMAR, DELAWARE |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Charles W Hastings | HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | 1week |
| | Due to (or as a consequence of): DIABETES | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D047676 | 8/7/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BETTER TOUCHMAT 9733 HEALTHWAY DR Berlin MD 21811

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Miller, Doris 70F 90-D-5635 8/7/01 2010

10MP

Michael A. Machonis
CJ
01-4610-047

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED 112101:ITEM#23a per ME G801 ss

## Certificate of Death

Reg. No. 2001 27173

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael A. Machonis

2. Date of Death: Month August, Day 11, Year 2001

3. Time of Death: 07:25 P.M.

4a. Facility Name (If not institution, give street and number): Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 069-36-0359

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sept. 17, 1945

9. Birthplace (State or Foreign Country): Australia

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1128 Crestview Drive

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Airforce- Sr. Master Sergeant

16b. Kind of Business/Industry: Military

17. Father's Name (First, Middle, Last): Edward Machonis

18. Mother's Name (First, Middle, Maiden Surname): Iris Goodchap

19a. Informant's Name/Relationship (Type, Print): Christine Gates/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1510 Lodge Pole Court Annapolis, MD 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MD. Veterans Cemetery

Date: Aug. 16 2001

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy. Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? Waived 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Theodore M. King

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27174

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Gerard Eugene Neumann | August 8, 2001 | 2:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 106-24-7124 | 1 X M 2 ☐ F | 73 Yrs. | | | Dec. 2, 1927 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 107 Monticello Ave | 21401 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No 1945-1961 | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Maritime Administrator | Merchant Marines |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Henry A. Neumann | Anna Marie Werckle |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Janice Neumann / Wife | 107 Monticello Ave. Annapolis, MD 21401 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Riverside Cemetery | 8/14/2001 | Orono, Maine |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael J. Shea | John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. liver failure | 5 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Cirrhosis | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| If FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

asbestosis exposure.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown | 1 ☐ Yes 2 X No | 1 ☐ Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Matthew J. Malta | D51819 | 8/8/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew J. Malta 1833 A. Forest Drive, Annapolis, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | Donna B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27175

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lena Marie Preller | August 10, 2001 | 6:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Nursing & Rehab. Center | Ellicott City | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-09-1448 | 1☐M 2☒F | 89 Yrs. | | | Jan. 29, 1912 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8619 Castle Mill Circle | 21236 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 4th Grade | | Seamstress | Clothing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jaspor Genco | Mary (surname unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Emelia E. Weisberg (Step-dghtr) | 8619 Castle Mill Circle, Baltimore, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Most Holy Redeemer | 8/13/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Amanda David | Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ISCHEMIC HEART DISEASE | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yaar) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ James P. Richardson MD | D27394 | 8/10/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES P. RICHARDSON MD 700 CROMWELL ROAD, CATONSVILLE, MD 21228

**State Registrar**

| 31. Date filed (Month, Day, Yaar) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-4762-003

B.K.S

JOHN C. PRANN

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 100201:ITEMS#23a,27 per ME G800 SS

# Certificate of Death

Reg. No. 2001 27176

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: JOHN C. PRANN

2. Date of Death (Month, Day, Year): AUG. 19, 2001

3. Time of Death: 0440 AM

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL GENERAL HOSPITAL

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 213-86-6611

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 19 1968

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1342 FOREST DRIVE

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: 1989-2001

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 1 yr.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STAFF SERGEANT

16b. Kind of Business/Industry: US ARMY

17. Father's Nama *(First, Middle, Last)*: JOHN L. PRANN

18. Mother's Neme *(First, Middle, Maiden Surname)*: VALERIA JONES

19a. Informant's Neme/Reletionship *(Type, Print)*: VALERIA JOHNSON (MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1350 FOREST DRIVE ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERAN CEMETERY

Date: 8/24/01

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Harry G. Reese III 00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disaase, or complications that ceused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diaease or condition resulting in death)

a. PROBABLE CARDIAC ARRYTHMIA ASSOCIATED WITH CORONARY ARTERY

Due to (or as a consequence of): TUNNELLING

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or aa a consequence of):

c. Due to (or as a conaequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauaa of death? 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findinga available prior to completion of cause of death? 1 [X] Yea 2 [ ] No

25. Waa casa referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: J M Titus

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: AUG. 19, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 22 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760, [illegible]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27177

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HELEN PARTRIDGE BURLINGAME
2. Date of Death: Month AUGUST Day 7 Year 2001
3. Time of Death: 10:55 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

**Funeral Director**

5. Social Security Number: 005-34-2550
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug 26, 1936
9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 475 St. Brides Court
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Black, White, etc. Specify: White

15. Decedent'a Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired): College Professor/Translator
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John F. Partridge
18. Mother's Name (First, Middle, Maiden Surname): Anna S. Dunbar

19a. Informant's Name/Relationship (Type, Print): Kenneth Burlingame/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 475 St. Brides Court, Severna Park, MD 21146

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Metro Crematory
Date: Aug 8, 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Ernest P. Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CANCER — 20 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if sny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse ot death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ateted.

29b. Signeture and title of certifier: Abraham MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): August 7, 2001

30. Nama end address of person who completed ceuse of death (Item 23a) (Type, Print): Jacob Abraham 600 North Wolfe Street, Baltimore, Md 21287

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

George V. Patrick
CJ
01-4736-027
AMND ITM#19a PR. INFMNT G&99 9-24-01 JB
UNPENDED 090601:ITEMS#23a,27,28a-f per ME G799 SS

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27178

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| George | Vernon | Patrick | August | 17 | 2001 | 02:00 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 291-70-8003 | 1☒ M 2☐ F | 37 Yrs. | | | | | 08/28/1963 | Arizona |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Columbia | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5906 Stevens Forest Road | 21075 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| | 5+ | Human Resource Consultant | Consulting |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Arthur V. Patrick | Joan R. Ruffner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOAN R. PATRICK / Mother ~~Joan V. Patrick~~ | 10709 Trafton Drive Upper Marlboro, Maryland 20774 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify) | Resurrection Cemetery | 08/24/2001 | Clinton, Maryland |

| 21. Signature of Funerel Service Licensee | 22. Name end Address of Facility |
|---|---|
| ▶ Joyce P. Kalas | George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY NORTRIPTYLINE INTOXICATION | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributs to the causes of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined | 7-17-01 | 12:53p M | 1☐ Yes 2☒ No | Unknown |

| 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Residence | 5909 Stevens Forest Rd. #4, Columbia, MD |

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. M. T. | O.C.M.E. | August 18, 2001 |

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | ▶ Geneva D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours efter death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27179

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Christina Olivia Ralston | August 8, 2001 | 6:13 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Future Care Chesapeake | Arnold | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-22-5810 | 1☐ M 2☒ F | 89 Yrs. | | | Oct. 26, 1911 | Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Arnold | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1058 Deep Creek Avenue | 21012 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Owner/Operator | Taverns |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Hackney | Lila McKenney |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Clyde McGowan/Son | 1058 Deep Creek Avenue Arnold, MD 21012 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Cedar Hill Cemetery | August 10, 2001 | Brooklyn, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas E. [illegible] | Barranco & Sons, P.A. Severna Park Funeral Home<br>495 Ritchie Hwy. Severna Park, MD 21146 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive heart failure | days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary artery disease | years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29e. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D-50725 | 8/9/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger 479 Jumpers Hole Rd Severna Park MD 21146

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Raynor
CJ
01-2243-033

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27180

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Raynor
2. Date of Death: Month April Day 21 Year 2001
3. Time of Death: 02:30 P.M.
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 216-64-5733
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/3/1954
9. Birthplace (State or Foreign Country): District of Columbia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 5724 64th Place
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Unknown
17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown
19a. Informant's Name/Relationship (Type, Print): Maryland Division Of Corrections
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 418, 8510 Corridor Road Savage, MD 20763
20a. Method of Disposition: 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) In-state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: State Anatomy Board Baltimore, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. HYPOXIC-ISCHEMIC ENCEPHALOPATHY WITH CEREBELLAR TONSILLAR HERNIATION COMPLICATING NARCOTIC INTOXICATION

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute Brochopnuemonia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day, Year): 4/20/01
28b. Time of Injury: found 1:15 A.M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: SUBJECT TOOK DRUGS
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): JAIL-MD House of Correction
28f. Location (Street and Number or Rural Route Number, City or Town, State): P.O Box 549 Jessup, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): April 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 24 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27181

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth A. Rodgers

2. Date of Death: Month August Day 9 Year 2001

3. Time of Death: 3:55 A M

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 207-10-4005

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1917

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: Queen Anne's

10c. City, Town or Location: Stevensville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3 Petinot Court

10f. Zip Code: 21666

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Service Rep.

16b. Kind of Business/Industry: Cable Television

17. Father's Name *(First, Middle, Last)*: Ray F. Mertz

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie O. Lohrman

19a. Informant's Name/Relationship *(Type, Print)*: Peter F. Rodgers / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 911 Monroe St. Stevensville, MD. 21666

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Crematory

Date: 8-10-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ C Brian Powell

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE — DAYS

Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. GANGRENOUS CHOLECYSTITIS — WEEKS

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY
PNEUMONIA

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Steven G. Proshan MD

29c. License number: D005 6357

29d. Date signed *(Month, Day, Year)*: August 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN G. PROSHAN, MD 64 FRANKLIN STREET ANNAPOLIS, MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 13 2001

32. Registrar's Signature: ▶ Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27182

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Wayne Stricklin
2. Date of Death (Month, Day, Year): August 9, 2001
3. Time of Death: 7:00 am
4a. Facility Name (If not institution, give street and number): 2918 Hampstead Mexico Road
4b. City, Town, or Location of Death: Hampstead
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-34-2276
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 7, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2918 Hampstead Mexico Road
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1954-1958
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Facilities Manager
16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): John R. Stricklin
18. Mother's Name (First, Middle, Maiden Surname): Betty Ann Leister

19a. Informant's Name/Relationship (Type, Print): The Rev. Melvina Stricklin, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2918 Hampstead Mexico Rd, Hampstead, MD 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Lutheran Cem.
Date: 8/13 2001
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: Steven Weller MD723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert tailure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Generalized Carcinomatosis | 2 weeks |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | metastatic lung cancer | 4 months |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: MD
29c. License number: D45274
29d. Date signed (Month, Day, Year): 8/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cho Maung, MD 555 South Center St Westminster md 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 20+IVA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27183

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOAN C. SCURLOCK
2. Date of Death (Month, Day, Year): AUG. 9 2001
3. Time of Death: 4:30 p M
4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 050-36-0112
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 10 1943
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1236 WASHINGTON DRIVE
10f. Zip Code: 21403
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PERSONNEL MANAGER
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): GEORGE CARROLL
18. Mother's Name (First, Middle, Maiden Surname): HELEN GRAHAM

19a. Informant's Name/Relationship (Type, Print): HERBERT SCURLOCK (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1236 WASHINGTON DR. ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 8/11/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese M00482
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MARYLAND 21401

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Fungal Pneumonia
Due to (or as a consequence of):
c. Fungal Sepsis
Due to (or as a consequence of):
d. multiple Myeloma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medicat examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Curtis Harris MD
29c. License number: D53306
29d. Date signed (Month, Dey, Year): 8/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Curtis Harris MD 600 Ridgely Avenue Ste 231 Annapolis MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 103001: ITEMS #23a,b,b,ptII,27 per ME (8006SS

# Certificate of Death

Reg. No. 2001 27184

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Data of Death Month / Day / Yaar | 3. Time of Deeth |
|---|---|---|---|
| Geraldine Elizabeth Stottlemyer | | February 17, 2001 | 3:00 P M |
| 4a. Facility Nama (If not institution, giva street and number) | 4b. City, Town, or Location of Daath | 4c. County of Deeth | |
| 19 N. Prospect Street #29 | Hagerstown | Washington | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Aga (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Yaar) | 9. Birthplace (Stata or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-50-8909 | 1☐M 2☒F | 68 Yrs. | | | Jan. 6, 1933 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒Yas 2☐No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of Whet Country? |
|---|---|---|
| 19 N. Prospect Street #29 | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forcas? If Yes, Giva Yaar or Detes: | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - Amarican Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yas 2☒No | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highast grade completed) | | 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Home |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Name (First, Middla, Meiden Sumame) |
|---|---|
| Paul Stottlemyer | Lena Beakley |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) |
|---|---|
| Kathleen E. Griffith Cousin | 13 McKeldin Drive Boonsboro, Maryland 21713 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Nama of cematary, cramatory or other place) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify) | Rose Hill Cemetery | 2/22/01 | Hagerstown, Maryland |

| 21. Signature of Funaral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| Gerald N. Minnich | Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland 21740 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused tha daath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only ona causa on each line.

Approximate Intarval Batwaen Onsat and Death

Immediate Cause (Finat disease or condition resulting in death)

a. RENAL FAILURE

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. DUE TO GANGRENE OF LOWER EXTREMITIES

Dua to (or as a consequenca of):

c. DUE TO ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yas, outcoma of pregnancy | 23d. Date of dalivary Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Liva birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

HYDROCEPHALUS; OLD INFARCT OF BRAIN

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of causa of death? |
|---|---|
| 1☒Yas 2☐No | 1☐Yas 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Placa of Death (Check only ona) | |
|---|---|---|
| 1☒Yes 2☐No | Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Home 5☐Rasidance 8☑Othar (Specify) Scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yaar) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yas 2☐No | |

| 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) | 28f. Location (Street end Numbar or Rurel Routa Number, City or Town, Stata) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledga, death occurred at tha time, data and place, and due to the cause(s) end mannar as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred at tha time, data and place, end dua to tha cause(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. License numbar | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| J M. K (for) | OCME | August 24, 2001 |

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

M. Karell M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Data filed (Month, Day, Yaar) | 32. Registrar's Signature |
|---|---|
| AUG 24 2001 | Geneva D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-4583-025
jhm
ASHLEY
TOLLENGER

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27185

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ashley Paige Tollenger

2. Date of Death Month / Day / Year: AUGUST 10, 2001

3. Time of Death: 05:15 PM

4a. Facility Name *(If not institution, give street and number)*: HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: HAVRE DE GRACE

4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 214-25-5066

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 12 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05/01/1989

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 520 Priestford Road

10f. Zip Code: 21028

10g. Citizen of What Country?: USA

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Middle School

17. Father's Neme *(First, Middle, Last)*: Garrett P. Tollenger

18. Mother's Name *(First, Middle, Meiden Surneme)*: Linda-Lee Burnett

19a. Informant's Neme/Relationship *(Type, Print)*: Garrett P. Tollenger- Father

19b. Meiling Address *(Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 520 Priestford Rd., Churchville, MD 21028

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Harford Memorial Grdns

Date: 8/15/01

20c. Location - City or Town, Stete: Aberdeen, MD

21. Signeture of Funeret Service Licensee: Elaine M. Smith

22. Name and Address of Fecility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart teilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

e. Head injuries

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*: 08-10-2001

28b. Time of Injury: 1639 M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject was a passenger in a motor vehicle involved in a collision

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: Highway bridge

28f. Location *(Streat end Number or Rurel Route Number, City or Town, Stete)*: Route 40, Hatem Bridge Harford County, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Stephen S. Radentz, M.D.

29c. License number: OCME

29d. Date signed *(Month, Dey, Year)*: AUGUST 11, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 14 2001

32. Registrer's Signeture: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

jhm

10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27186

Wilson, Gilbert

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gilbert Woodrow Wilson

2. Date of Death: Month August Day 11 Year 2001

3. Time of Death: 2:10 p.m

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre DeGrace

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 214-24-6170

6. Sex: ☒ 1 M ☐ 2 F

7. Age (If yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10, 1912

9. Birthplace (State or Foreign Country): North Carolina

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: ☒ 1 Yes ☐ 2 No

10e. Street and Number: 900 Ontario Street

10f. Zip Code: 21078

10g. Citizen of What Country? U.S.A.

11. Marital Status: ☐ 1 Never Married ☐ 2 Married ☒ 3 Widowed ☐ 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes ☐ 2 No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Diner

17. Father's Name (First, Middle, Last): Garfield Martin Wilson

18. Mother's Name (First, Middle, Maiden Surname): Verna Leota Bennet

19a. Informant's Name/Relationship (Type, Print): Sara Jane Brady (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 Ontario Street, Havre de Grace, MD 21078

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens

Date: 8/14/01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Kirsten Arnold Wagstaffe

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

CAS

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma - primary unknown — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cognitive cardiomyopathy

coronary artery disease

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☐ 2 No ☐ 3 Probably ☒ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No

26. Place of Death (Check only one): Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA Other: ☒ 4 Nursing Home ☐ 5 Residence ☐ 6 Other (Specify)

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C Eck MD

29c. License number: D31712

29d. Date signed (Month, Day, Year): 8/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK JR MD 219 W. Bel Air Ave. Aberdeen MD 21001

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: ▶ Brenda G Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

6+1

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27187

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leroy Willett

2. Date of Death: Month August Day 10, Year 2001

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): Solomons Nursing Center

4b. City, Town, or Location of Death: Solomons

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 215-36-3697

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 4, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Calvert | 10c. City, Town or Location: Lusby | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1640 Coster Road | 10f. Zip Code: 20657 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Mechanic

16b. Kind of Business/Industry: District of Columbia Government

17. Father's Name (First, Middle, Last): Lee Gross

18. Mother's Name (First, Middle, Maiden Surname): Florence Willett

19a. Informant's Name/Relationship (Type, Print): Frances Willett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1640 Coster Road Lusby, Maryland 20657

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens | Date: 8/17/01

20c. Location - City or Town, State: Leonardtown Maryland

21. Signature of Funeral Service Licensee: Lloyd A. Gross 191

22. Name and Address of Facility: Adams Funeral Home P.A. Aquasco, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Uremia — 8 days
Due to (or as a consequence of):
b. End Stage Renal disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

(1) Insulin dependant Diabetes Mellitus
(2) Bilateral Lower Extremity amputation-coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A T Munshi M.D. Attending Physician

29c. License number: D19427

29d. Date signed (Month, Day, Year): 8/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANWAR MUNSHI M.D. 110 Dosp Road. Pr. Frederick MD 20628

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27188

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard H. Wallace
2. Date of Death: Month August Day 11 Year 2001
3. Time of Death: 1:00 A.M.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 408-24-1318
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 12, 1918
9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Hanover
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7548 Old Telegraph Road, #302
10f. Zip Code: 21076
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Military
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Fred F. Wallace
18. Mother's Name (First, Middle, Maiden Surname): Unavailable

19a. Informant's Name/Relationship (Type, Print): Richard T. Wallace/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 London Court, Toms River, NJ 08753

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Aug. 13, 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas E. [illegible]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Coronary artery disease
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): August 11 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Apolo Onesimo 301 Hospital Drive, Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

RICHARD H. WALLACE

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27189

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Henry Znamirowski
2. Date of Death: Month August, Day 8, Year 2001
3. Time of Death: 2:25 PM
4a. Facility Name (If not institution, give street and number): Renaissance Gardens Nursing Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-01-7995
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 5, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8810 Walther Blvd., Apt. 1401
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Design Engineer
16b. Kind of Business/Industry: Product Development

17. Father's Name (First, Middle, Last): Victor Znamirowski
18. Mother's Name (First, Middle, Maiden Surname): Mary Kendryna

19a. Informent's Neme/Relationship (Type, Print): Mary Elaine Znamirowski (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8810 Walther Blvd., Apt.1401, Baltimore, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Crest Lawn Cemetery
Date: 8/11/01
20c. Location - City or Town, State: Marriottsville, MD

21. Signeture of Funeral Service Licensee: Brian A. Miller
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)
a. Cerebrovascular accident — 2 weeks

Due to (or as a consequence of):
b. Multi infarct dementia — 1 year.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signifficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Kendall Faulkner
29c. License number: D25643
29d. Date signed (Month, Day, Year): 08/08/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): KR Faulkner MD/8800 Walther Blvd/Baltimore MD 21234

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: Denise D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Znamirowski, Henry 8/8/01 2:25PM 2:25 PM

15+1

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#6 PR. F.H. G799 9-6-01 JAB

# Certificate of Death

Reg. No. 2001 27190

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HARRY GARDNER ANNIS, JR. | August 23, 2001 | 9:40 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 13504 SLOAN STREET | ROCKVILLE | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-10-7467 | 1 [X] M 2 [ ] F | 84 Yrs. | | | JULY 25, 1917 | WASHINGTON, D.C. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | ROCKVILLE | 1 [ ] Yes [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13504 SLOAN STREET | 20853 | UNITED STATES OF AMERICA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced | [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII | 1 [ ] Yes [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 3 | PRINTER | PRINTING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HARRY GARDNER ANNIS, SR. | EMILY NEWTON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| KATHLEEN L. AMOS, (DAUGHTER) | 13504 SLOAN STREET; ROCKVILLE, MARYLAND 20853 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | FORT LINCOLN CEMETERY | AUG. 30, 2001 | BRENTWOOD, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| James A. Schwartz | HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC COLON CANCER | 4 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)

27. Manner of Death [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D08754 | AUGUST 24, 2001 |

| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | |
|---|---|
| THOMAS BENSINGER, M.D. | 7525 GREENWAY CENTER DRIVE, SUITE 205 GREENBELT, MARYLAND 20770 |

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | Geneva D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#6

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27191

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Allen Jr.
2. Data of Death Month: August Day: 24, Yaar: 2001
3. Tima of Death: 6:00 AM
4a Facility Nama (If not institution, giva street and number): 2029 N. Smallwood St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 241-26-2692
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 10, 1922
9. Birthplace (State or Foraign Country): North Carolina

Usual Residence of Decedent

10a. Steta: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2029 N. Smallwood St.
10f. Zip Coda: 21216
10g. Citizen of What Country? USA

11. Merital Stetus: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaer or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada compleated): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Machinist
16b. Kind of Businass/Industry: Chemical Co.

17. Fathar's Name (First, Middla, Last): Charles Allen Sr.
18. Mother's Nama (First, Middle, Maiden Surnama): Anna Lee Allen

19a. Informant's Name/Relationship (Type, Print): Ms. Alice P. Sidbury (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3006 Woodland Ave. Balto. Md. 21215

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematery, cramatory or othar place): Mt. Zion
Data: 8/30/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funaral Service Licensee: Joseph L. Russ
22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath):
a. Lung Carcinoma — 1 month
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or es a consequanca of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco usa contribute to the causa of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarred to medical examinar? 1 [ ] Yas 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigation 6 [ ] Could not be datermined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and mannar stated.

29b. Signeture and title of certifiar: Timothy J. Kay MD
29c. Licansa number: D 37458
29d. Data signed (Month, Day, Year): 8/24/01

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Timothy J. Kay MD Dept FM 29 S. Paca St. Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signeture: Georgia D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles Allen 8/24/01 6 Am

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMEND ITEMS #5&7 PER FH G798 8/27/01 JH

Reg. No. 2001 27192

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gloria AKins

2. Data of Death Month/Day/Year: August 20, 2001

3. Time of Death: 00:45

4a. Facility Name *(If not institution, give street and number)*: 1732 D Fountain Rock way

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-44-7888

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: ~~54~~ 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 8-23-45

9. Birthplace *(State or Foreign Country)*: Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedant

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1732 D Fountain Rock Way

10f. Zip Code: 21040

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ ~~Married~~ 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ ~~No~~ If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ ~~No~~ Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/A

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian Technician

16b. Kind of Business/Industry: Library

17. Father's Name *(First, Middle, Last)*: William Arthur Downing

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Bishop

19a. Informant's Name/Relationship *(Type, Print)*: Charles AKins - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1732 D Fountain Rock Way Edgewood, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Clark united Methodist cemetery

Data: 8-24-01

20c. Location - City or Town, State: Belair, Maryland

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto MD 21213

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Lung Cancer by bronchoscopic biopsy on

Due to (or as a consequence of): August 16, 2001

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory failure due to lung cancer — days

Due to (or as a consequence of):

c. Asthma — months

Due to (or as a consequence of):

d. Chronic obstructive lung disease — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Albert S.C. Sun, M.D.

29c. License number: D18779 Maryland

29d. Date signed *(Month, Day, Year)*: August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert S.C. Sun, M.D. 1716 Harford Road, Suite 105, Hallston, Maryland 21047

**State Registrar**

31. Date filed *(Month, Day, Year)*

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEM #4 PER PHY G799 9/06/01 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27193

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas Lee Allman Jr.

2. Date of Death Month August Day 11 Year 2001

3. Time of Death 1030 AM

4a. Facility Name (If not institution, give street and number): Medstar 207ANGUS DRIVE

4b. City, Town, or Location of Death: Aberdeen

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 223-44-3447

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

6. Date of Birth (Month, Day, Year): December 3, 1935

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 207 Angus Drive

10f. Zip Code: 21001

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: NAVY 1964-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): ___

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Manager

16b. Kind of Business/Industry: Public Transportation

17. Father's Name (First, Middle, Last): Thomas Lee Allman, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Drucilla Watson

19a. Informant's Name/Relationship (Type, Print): Charla Allman/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Angus Dr. Aberdeen, MD, 21001

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Found. Date: 8/11/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ R. O B

22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ___ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D37089

29d. Date signed (Month, Day, Year): 8 15 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE LEFF 5505 HOPKINS BAYVIEW CR. BALTIMORE MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4A
15
26
8
12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27194

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HUBERT ANDREWS
2. Date of Death: Month 08 Day 21 Year 01
3. Time of Death: 6:43 P.M.
4a. Facility Name (If not institution, give street and number): R.A. COOLEY SHOCK TRAUMA CENTER
4b. City, Town, or Location of Death: BALTIMORE, MD
4c. County of Death:

**Funeral Director**

5. Social Security Number: 579-46-9884
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/03/13
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10e. State: Maryland
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2040 Riverdowns Court
10f. Zip Code: 21050
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1930-54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Captain US Army
16b. Kind of Business/Industry: U.S. Military

17. Father's Name (First, Middle, Last): Ivey S. Andrews
18. Mother's Neme (First, Middle, Meiden Surneme): Lula C. Taylor

19e. Informant's Name/Relationship (Type, Print): Romina Sweitzer / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 61 Forest Hill, MD 21050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Maplewood Cemetery
Date: August 27, 2001
20c. Location - City or Town, State: Wilson, NC

21. Signature of Funeral Service Licensee: Bryce M Markwith
22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Immediate Cause (Final disease or condition resulting in death):
a. Terminatie Brain Injury
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximete Interval Between Onset and Death:

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Yeer): 8/13/01
28b. Time of Injury: unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: fell down steps
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2040 Riverdown Court Forest Hill, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Nathaniel McQuay, Jr.
29c. License number: P14152
29d. Deta signed (Month, Day, Year): 8/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. McQuay JR
DEPT OF SURGERY R.A. COOLEY SHOCK TRAUMA CENTER (410) 328-5830

**State Registrar**

31. Date filed (Month, Day, Yeer): AUG 27 2001
32. Registrar's Signature: Penny D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#26 PR. MD. G798 8-27-01 JAB

# Certificate of Death

Reg. No. 2001 27195

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOLORES H. BARTAS
2. Date of Death (Month, Day, Year): AUGUST 20, 2001
3. Time of Death: 6 bc A M
4e. Facility Name (If not institution, give street and number): 8 ROBINS NEST COURT
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-38-6893
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/11/32
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 200 S. EAST AVE.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
18b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): JOSEPH J. HAJEWSKI
18. Mother's Name (First, Middle, Maiden Surname): ANTOINETTE KOZLOWSKI

19a. Informant's Name/Relationship (Type, Print): MISS GLORIA BARTAS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 ROBINS NEST CT. RANDALLSTOWN, MD. 21133

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): ST. STANISLAUS
Date: 8/25/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski
Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. progressive supra nuclear palsy — 6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnent in the pest 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Wes cese referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): DAUGHTER'S
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☑Residence 8☒Other (Specify) RESIDENCE

27. Manner of Death: 1☑Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: mayms
29c. License number: D30377
29d. Date signed (Month, Day, Year): 8/21/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Robert m. cooper MD 6503 Park Heights Ave Baltimore MD 21215

**State Registrar**

31. Dete liled (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospitel or Attending Physicien:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item 20b PER FH G798 08/27/01 **Certificate of Death** RR

Reg. No: 2001 27196

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MARGARET | BUTLER | | AUGUST 25 2001 | 12:35 PM. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Future Care Homewood | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-18-7925 | 1☐ M 2☒ F | 76 Yrs. | | | MARCH 11, 1925 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3602 W. GARRISON AVE. | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8TH GRADE | | HOMEMAKER | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN HENRY BROOKS | MARY ROBINSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RENEE BUTLER (DAUGHTER) | 3602 W. GARRISON AVE., BALTIMORE, MD 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Mt. Zion Cemetery | 08/31/01 ~~08/24/2001~~ | LANSDOWNE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert N. Wall | JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage renal disease | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1Ho Cerebrovasular disease. 1Ho Bactraemia

1Ho Above Knee Amputation of leg

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown | 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

| 29b. Signeture end title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Darshan | D17537 | 8-26-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DARSHAN S. SALUJA MD 1600 W. Mount Royal Ave Balto 21217

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| AUG 27 2001 | Renee D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27197

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Maragret Murphy Berger

2. Date of Death Month Day Year: August 26 2001

3. Time of Death: 11:10 am

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 214-01-4925

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul. 20, 1919

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1245 Elm Road

10f. Zip Code: 21227

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Coffee Shop

17. Father's Name (First, Middle, Last): Arthur G. Murphy

18. Mother's Name (First, Middle, Maiden Surname): Emma Nordt

19a. Informant's Name/Relationship (Type, Print): Herman E. Berger Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1245 Elm Rd., Arbutus, MD 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery at Garrison Forrest

Date: 8-31-2001

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Stan P. Ambush

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter tha moda ot dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediata Causa (Final disease or condition resulting in death): a. Advanced CA Lung (Right) — One Year

Sequentially list conditions, it any, leading to immedieta causa. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal daath 3☐ Ectopic pregnancy 4☐ Pregnant at tima of death 5☐ Other (specify) 9☐ Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of daath? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Daath (Check only ona)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describa how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: MD Pg Tm

29c. Licensa number: P13598

29d. Date signed (Month, Day, Yeer): August 26, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Dr. Mehdi Azadi

**State Registrar**

31. Date filed (Month, Dey, Year): AUG 27 2001

32. Registrar's Signature: Sandra D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME BERGER, MARGARET Arbus TA

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #26 PER PHY G798 8/29/01 JH

# Certificate of Death

Reg. No. 2001 27198

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| MARY E. BROWN | August 15, 2001 | 3:35 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHN HOPKINS BAYVIEW | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-22-5000 | 1☐ M 2☒ F | 89 Yrs. | | | 07-11-1912 | VIRGINIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 108 LEE LAWRENCE CT. | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elamantary/Secondery (0-12) | College (1-4or 5+) | | |
| 9 | | COOK | FOOD SERVICE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surneme) |
|---|---|
| CHRISTOPHER BOWSER | MARY PARKER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EARLINE M. BROWN, DAUGHTER | 108 LEE LAWRENCE CT, DUNDALK, MD 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | METRO CREMATORY | 8-29-01 | BALTO. MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| William Howell | HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart teilure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Coronary artery disease | |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

| 29b. Signeture and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Ten R. Richardson MD | D53824 | 8/23/01 |

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

Ten R. Richardson MD 4426 Park Heights Ave Balto, MD 21215

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| AUG 27 2001 | G. Sparks |

**State Registrar**

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27199

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| VENCENTA MARY BROWN | AUGUST | 25 | 2001 | 3:16 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HARBOR HOSPITAL | BALTIMORE | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 217-38-1050 | 1☐M 2☒F | 69 Yrs. | | | | | Dec. 20 1931 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | n/a | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 321 Jeffery Street | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 5 | 0 | Factory worker | Maryland Paper Box |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Samuel J. Patti | Rose Valsoma |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard J. Brown, Jr. (Son) | 3833 8th Street, Baltimore, Md. 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holy Cross Cemetery | 8/28/2001 | Baltimore, Md. |

21. Signature of Funeral Service Licensee: Frank S. Polyniak

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEVER RESPIRATORY TRACT BLEED | 30 MINUTES |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. SMALL CELL LUNG CANCER | 15 MONTHS |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☒Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MEDICAL RESIDENT | RES000 | AUGUST, 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMED ALATTAR 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | Jennifer D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27200

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARY ANN CHACONAS | AUGUST 23, 2001 | 7:25 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| SUBURBAN HOSPITAL | BETHESDA | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-28-7180 | 1☐M 2☒F | 73 Yrs. | | | JAN. 26, 1928 | WASHINGTON, D.C. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | ROCKVILLE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 235 CONGRESSIONAL LANE | 20852 | UNITED STATES OF AMERICA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | SECRETARY | FEDERAL GOVERNMENT |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| TOM SAKADALES | CALOMERIS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| THEODORE G. CHACONAS (HUSBAND) | 235 CONGRESSIONAL LANE; ROCKVILLE, MARYLAND 20852 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | PARKLAWN MEMORIAL PARK | AUG. 27, 2001 | ROCKVILLE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Alan J Donnell | HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Bladder Cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease
Diabetes Mellitus
Coronary Artery Disease

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yas 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was casa referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signatura and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ KR Lillie MD | D53244 | August 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ Bonnie D Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mary Chaconas 8/29/01 0125 am.

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27201

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Diana | V. | Curtian | August | 21 | 2001 | 7:57 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| THE Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-34-8343 | 1☐M 2☒F | 64 Yrs. | | | | | April 29, 1937 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 302B Juneberry Way | 21061 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Bookkeeper | Asphalt & Paving Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Schneider | Elsie Trimper |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Diana L. Wilson / Daughter | 331 Stafford Drive, Baltimore, Maryland 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Glen Haven Memorial Park | 8/25/2001 | Glen Burnie, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ John F. Miller | McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. cytomegalovirus infection | one week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): lung transplantation | two years |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Steven Dudek MD | D0053341 | August 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Dudek, MD, Johns Hopkins Hospital, Baltimore, Maryland, 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ per P Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Amend Item#8 perFHG798 8/31/01 EW

# Certificate of Death

Reg. No. 2001 27202

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Virginia Lois Compton

2. Date of Death: Month August Day 23 Year 2001

3. Time of Death: 4:30PM

4a. Facility Name *(If not institution, give street and number)*: 2204 Rockwell Avenue

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 237-30-2160

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: ~~Aug. 23, 2001~~ 5/17/26

9. Birthplace *(State or Foreign Country)*: NC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 2204 Rockwell Ave.

10f. Zip Code: 21228

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent'a Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Food Service

17. Father's Neme *(First, Middle, Last)*: Willis Howell

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Alice Sullivan

19a. Informent's Neme/Relationship *(Type, Print)*: Patricia D. Shipley, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2204 Rockwell Ave. Catonsville, MD. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedarwood Cemetery

Date: 8-28-01

20c. Location - City or Town, State: Roanoke Rapids, NC

21. Signature of Funeral Service Licensee: Rebecca Robbins

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia — 7day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Emphysema — 10yr

Due to (or as a consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other signiflcant conditlons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D2544

29d. Date signed *(Month, Day, Year)*: 8/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Kellman

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 27 2001

32. Registrar's Signature: [signature] Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27203

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ella M. Calhoun

2. Date of Death: Month August Day 18, Year 2001

3. Time of Death: 6:45pm

4a. Facility Name (If not institution, give street and number): 3411 Redmond Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-36-2844

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-09-39

9. Birthplace (State or Foreign Country): TN.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3411 Redmond Road

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): 6yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labortory Technician

16b. Kind of Business/Industry: J.H. Bayview Med. Ctn.

17. Father's Name (First, Middle, Last): John Addington, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Ceola Braxton

19a. Informant's Name/Relationship (Type, Print): Charles Calhoun

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207: 3411 Redmond Road Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Woodlawn Cemetery Date: 08-24-2001

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Jerome F. Thompson

22. Name and Address of Facility: WM.C. March-West 4300 Wabash Avenue Baltimore, Maryland 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic pancreatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopay findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residenca 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Larry Waterbury, M.D.

29c. License number: DO 9559

29d. Date signed (Month, Day, Year): 8/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LARRY WATERBURY, M.D. JHBMC 4940 EASTERN AVE., BALT., MD 21224.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27204

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Barbara Jean Durst

2. Data of Death — Month: August Day: 22, Yaar: 2001

3. Tima of Death: 16:01

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Locaiion of Death: Olney

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 220-60-4543

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Aug. 22, 1951

9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Rasidance of Decedant

10e. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 2820 Blue Spruce Lane

10f. Zip Coda: 20906

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grade completed)*: Elamantary/Saconday (0-12): 12 / College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Program Specialist

16b. Kind of Businass/Industry: Federal Government

17. Fathar's Nama *(First, Middla, Last)*: Robert Thomas Newman

18. Mother's Nema *(First, Middla, Maidan Sumama)*: Maxine Leta Steele

19a. Informant's Name/Ralationship *(Type, Print)*: Richard M. Gable / Companion

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 2820 Blue Spruce Lane, Silver Spring, MD 20906

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Crematory

Data: 8/27/01

20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funaral Sarvice Licensee: Alan J Donnell

22. Nama and Addrass of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceusa on aach lina.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Coronary Artery Disease — 8 Months

Dua to (or as a consaquance of):

b. Hypercholesterolemia — Years

Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 8☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad

28e. Placa of Injury - At home, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: Richard Weinstein, MD

29c. Licansa number: D42777

29d. Data signad *(Month, Day, Yaar)*: August 23, 2001

30. Nama and addrass of parson who completad ceusa of daath (Item 23a) (Type, Print): Richard Weinstein 18111 Prince Philip Dr. Olney, MD 20832

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: AUG 27 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27205

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| WEAVER DOYLE | AUGUST 19, 2001 | 2:40 P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| CASEY HOUSE, MONTGOMERY HOSPICE | ROCKVILLE | MONTGOMERY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-07-7660 | XX 1 M 2 F | 84 Yrs. | | | FEB. 21, 1917 | PENNSYLVANIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | CHEVY CHASE | 1 Yes XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7220 DELFIELD STREET | 20815-4046 | UNITED STATES OF AMERICA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married XX Married 3 Widowed 4 Divorced | XX Yes 2 No If Yes, Give Year or Dates: 1943-1945 | 1 Yes XX No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | MANAGER | WASHINGTON GAS LIGHT COMPANY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM DOYLE | CLARA GODFREY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MILDRED P. DOYLE (WIFE) | 7220 DELFIELD STREET; CHEVY CHASE, MARYLAND 20815-4046 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) | FORT LINCOLN CREMATORY | AUGUST 23, 2001 | BRENTWOOD, MARYLAND |

21. Signature of Funeral Service Licensee: Jno D. Schmauch

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC CARCINOMA | 5 MONTHS |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. COLON CANCER | 1 YEAR |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

6/23/01

IF FEMALE:

| 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 XX No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER

PATHOLOGIC FRACTURE OF THE RIGHT HUMERUS

23e. Did tobacco use contribute to the cause of death? 1 Yes XX No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes XX No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| XX Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 XX Other (Specify) HOSPICE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| E. P. Libre M.D. | D09470 | AUGUST 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EUGENE P. LIBRE, M.D., 10400 CONNECTICUT AVENUE, SUITE #606 KENSINGTON, MARYLAND 20895

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RJD
MICHELE DAWSON
01-4791-510

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27206

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MICHELE DAWSON DUVALL
2. Date of Death (Month, Day, Year): AUGUST 21, 2001
3. Time of Death: 0225 A.M.
4a. Facility Name *(If not institution, give street and number)*: 405 S. MADERIA ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-92-8910
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/5/67
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 405 S. MADERIA STREET
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: VINCENT DAWSON
18. Mother's Name *(First, Middle, Maiden Surname)*: LYNDEE BAKER

19a. Informant's Name/Relationship *(Type, Print)*: MRS. LYNDEE MILLER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2199 LAKE MEADE EAST BERLIN, PA. 17316

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BAYVIEW CREMATORY | Date: 8/27/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Eugene J. Latta Jr.
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE GUNSHOT Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* (SCENE)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 8/21/01
28b. Time of Injury: 1:55 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT WAS SHOT
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 405 South Maderia Street Baltimore, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. T.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: AUGUST 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TIRUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 27 2001
32. Registrar's Signature: Penny B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #24a & 27 PER PHY 6799 9/07/01 JH

# Certificate of Death

Reg. No. 2001 27207

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SIDNEY DANIELS
2. Date of Death: Month 8 Day 24 Year 01
3. Time of Death: 1152 4M
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 282-16-4862
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-28-1921
9. Birthplace (State or Foreign Country): OHIO

**To Be Completed by Funeral Director**

Usual Residence of Decedent
10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3523 DENISON RD
10f. Zip Code: 21215
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- tt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Rece - American Indien, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 6
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): PASTOR
16b. Kind of Business/Industry: MINISTRY
17. Father's Name (First, Middle, Last): WILLIAM DANIELS
18. Mother's Name (First, Middle, Maiden Surneme): ESTHER BERRY
19a. Informant's Name/Relationship (Type, Print): EMMA LEE DANIELS, WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3523 DENISON RD, BALTIMORE, MD 21215
20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): GARRISON FOREST
Date: 08-31-01
20c. Location - City or Town, Stete: OWING MILLS, MD
21. Signature of Funeral Service Licensee: ▶ Willie E Howell Jr
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or es e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown
23c. If yes, outcome of pregnency: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery DISEASE

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to comptetion of cause of death? 1 ☐ Yes 2 X No
25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.
29b. Signature and title of certifier: ▶ Walker Billy . MD
29c. License number: D46612
29d. Date signed (Month, Day, Year): 8-24-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter Bellew. 22. S. Green St. Baltimore. MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: ▶ Bonnie B. Sparks

24a
27

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27208

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leslie Eichhorn
2. Date of Death (Month, Day, Year): Aug 14 2001
3. Time of Death: 1210pm
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 215-18-5631
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 3, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1500 Regester Avenue
10f. Zip Code: 21239
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 11/42-10/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Merchandising Manager
16b. Kind of Business/Industry: Merchandising
17. Father's Name (First, Middle, Last): Frederick Eichhorn
18. Mother's Name (First, Middle, Maiden Surname): Wilhemina Schmidt
19a. Informant's Name/Relationship (Type, Print): John R. Eichhorn-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1500 Regester Avenue, Baltimore, Maryland 21239
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Loudon Park Cemetery
Date: 8-17-01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Lisa S. Jefferson
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory failure — 5 months
Due to (or as a consequence of):
b. Pulmonary fibrosis — 1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gary Kozlow
29c. License number: D41617
29d. Date signed (Month, Day, Year): Aug 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kozlow MD 10805 Hickory Ridge Rd Columbia Md 21044

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27209

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Anna P. Esposito
2. Date of Death Month Day Yaar: August 22, 2001
3. Time of Death: 5:35pm
4a. Facility Name *(If not institution, giva street and number)*: Manor Care
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-03-1869
6. Sax: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 10-25-1913
9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. Stete: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yas 2☐No
10e. Street and Number: 230 S. Eaton Street
10f. Zip Coda: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yas 2☒No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 8th; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Receptionist
16b. Kind of Businass/Industry: Our Lady of Pompei Church
17. Fathar's Nama *(First, Middle, Last)*: Nicola Farinacci
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Angela Petroniero
19a. Informant's Name/Relationship *(Type, Print)*: son Joseph Esposito
19b. Mailing Address *(Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code)*: 4910 Silver Spring Rd., Baltimore, Maryland 21128
20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: Holy Redeemer Cemetery
Data: 8/25/01
20c. Location - City or Town, Stata: Baltimore, Maryland
21. Signature of Funeral Sarvice Licensaa: Joseph N. Zannino Jr.
22. Nama and Address of Facility: Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one causa on aach lina.

Approximate Interval Batween Onset and Death

Immediata Causa (Final disaase or condition resulting in death)
a. End Stage Dementia — 10 years
Dua to (or as a consequanca of):
b. Hypertension
Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaase or Injury that initiatad avants rasulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of ceusa of death? 1☐Yas 2☐No

25. Was casa relarrad to medical examinar? 1☐Yas 2☒No

26. Piece of Deeth *(Chack only one)*: Hospital: 1☐inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Homa 5☐Rasidance 6☐Othar *(Specify)*

27. Mannar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding invastigation 8☐Could not be determined

28a. Date of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Piece of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Certifying Phyaician:** To tha best of my knowladga, daath occurred at tha time, date and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to the causa(s) and mannar stated.

29b. Signatura and Titla of cartifiar: MD
29c. Licansa number: D53462
29d. Data signed *(Month, Day, Year)*: 8/23/01

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Jude Muneses MD 7845 Oakwood Road Glen Burnie MD 21061

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by tha attanding physician and completely filled in by the funaral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: AUG 27 2001
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

Anna Esposito, Expired 535 8-22-01
DOB: 10-25-13; SSN: 215-03-1869
12

Kenis Falconer
CJ
01-4760-031

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27210

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kennis Cecilia Falconer

2. Date of Death: Month: August; Day: 18; Year: 2001

3. Time of Death: 05:12 P.M.

4a. Facility Name (If not institution, give street and number): 7401 New Hampshire Avenue

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 212-37-7726

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 26 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Oct. 31, 1974

9. Birthplace (State or Foreign Country): Jamaica

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7401 New Hampshire Avenue

10f. Zip Code: 20912

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Records Clerk

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Denston Falconer

18. Mother's Name (First, Middle, Maiden Surname): Fay Dunkley

19a. Informant's Name/Relationship (Type, Print): Fay Dunkley / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6611 Patterson Street, Riverdale, Maryland 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery

Date: Aug. 30, 2001

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE STAB AND CUTTING WOUNDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Found 8/18/01

28b. Time of Injury: Found 5:00 P. M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how Injury occurred: Subject was stabbed and cut

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7401 New Hampshire Avenue Takoma Park, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27211

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| William H. Federline, Jr. | August 23, 2001 | 7:22 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-26-2968 | 1 [X] M 2 [ ] F | 81 Yrs. | | | May 26, 1920 | Montgomery |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Silver Spring | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13730 Notley Road | 20904 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Carpenter | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Henry Federline, Sr. | Mary Oresta Daily |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cheryl Federline - Daughter | 1931 Bronzegate Blvd., Silver Spring, MD 20904 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | George Washington | 8/27/2001 | Adelphi, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., SilverSpring, MD 20904 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Acute Myocardial Infarction | minutes |
| Due to (or as e consequence of): | | |
| Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last | b. Coronary Artery Disease | Years |
| Due to (or ss a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Dete of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Wes case referred to medicat examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D43302 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. Ozanne-Blankford MD, 3305 North Leisure World Blvd, Silver Spring Maryland 20906

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 19a PER FH G798 **Certificate of Death** 08/27/01 RR Reg. No. 2001 27212

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| DOROTHY JONES FITZGERALD | | | AUGUST 23 2001 | 9:00 AM M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| 120 MARYLAND AVE. | PASADENA | | ANNE ARUNDEL CO. | |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 230-28-0208 | 1☐M 2☒F | 87 Yrs. | | | | | March 30 1914 | Virginia |

To Be Completed by Funeral Director

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel Co. | Pasadena | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 120 Maryland Ave. | 21122 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | 0 | Housewife | Home Owner |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Claude Gray | Eva Truslow |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James M. Fitzgerald Son ~~(Husband)~~ | 10453 Clarence Barnes Road, Princess Anne, Md. 21853 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Meadowridge Mem. Pk. | Maus. 8/27/2001 | Elkridge, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Robert T. Ellis | McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 |

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Batween Onsat and Death |
|---|---|---|
| Immediata Causa (Final disaase or condition resulting in death) | a. Acute myocardial Infarction | |
| Sequentially tist conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Dua to (or as a consequence of): | |
| | c. Dua to (or as a consequence of): | |
| | d. Dua to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Liva birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Wara autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yas 2☒No |

| 25. Was casa rafarrad to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify) |

| 27. Manner of Daath | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined | | M | 1☐Yas 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifiar (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated.

| 29b. Signature and title of cartifier | 29c. License number | 29d. Date signed (Month, Day, Yaar) |
|---|---|---|
| ▶ [signature] debt | D23624 | Aug 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASANT K. KHANDELWAL 1600 S. Crain Hwy #102 Glen Burnie MD 21061

| State Registrar | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|---|
| | AUG 27 2001 | Bernice D Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27213

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine Irene Fritz
2. Date of Death (Month, Day, Yaar): August 24, 2001
3. Time of Death: 10:15 AM
4a. Facility Name (If not institution, give street and number): 4541 Aspen Mill Road
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-01-2503
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 3, 1911
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4541 Aspen Mill Road
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Denis Fitzpatrick
18. Mother's Name (First, Middle, Maiden Surname): Josephine Evans

19a. Informant's Name/Relationship (Type, Print): Catherine A. Fritz/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4541 Aspen Mill Road Perry Hall Maryland 21236

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer
Date: 8/28/01
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton ▶ Christina L Hilton
22. Name and Address of Facility: Leopard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finat disease or condition resulting in death)
a. METASTATIC TRANSITIONAL CELL CA OF RENAL PELVIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: 3 months

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0042880
29d. Date signed (Month, Day, Yaar): 08/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS B. SMITH 8322 BELLONA AVE TOWSON MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

DHMH 17 Rev 1/2001

ORIGINAL

01-4805-510
mnmr
Kenyon Fuller-Baker

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27214

UNPENDED ITEMS #23a,27 per ME G799 092801 ss

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: KENYON FULLER-BAKER
2. Date of Death Month/Day/Year: August 21, 2001
3. Time of Death: 1644 pm
4a. Facility Name *(If not Institution, give street and number)*: Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 066-74-5547
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 21 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-29-1979
9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6000 YORKWOOD DR
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT
16b. Kind of Business/Industry: EDUCATION

17. Father's Name *(First, Middle, Last)*: DEWAYNE BAKER
18. Mother's Name *(First, Middle, Maiden Surname)*: DEBORAH FULLER SELLS

19a. Informant's Name/Relationship *(Type, Print)*: DEWAYNE BAKER, FATHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 266 SYCAMORE ST, BUFFALO, NEW YORK 14204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: RIDGE LAWN — Date: 8-27-01
20c. Location - City or Town, State: NEW YORK

21. Signature of Funeral Service Licensee: ▶ Willie E. Howell
22. Name and Address of Facility: HOWELL FUNERAL HOME, 4600 LIBERTY HGHTS AVE, BALTO.MD 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. THROMBOTIC THROMBOCYTOPENIC PURPURA (TTP)
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 22, 2001
30. Name and address of person who completed cause of death *(Item 23a)* (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 27 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27215

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| WILLIAM B. GRAMS | AUGUST 23 2001 | 7:44 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1449 PATAPSCO STREET | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-22-1243 | 1☒M 2☐F | 72 Yrs. | | | Jan. 16 1929 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | n/a | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1449 Patapsco Street | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | +3 | Maintenance Supervisor | ASARCO |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Grams | Catherine Rehmert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Susan Lambert (Daughter) | 1447 Patapsco Street, Baltimore, Md. 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Holy Cross Cemtery | 8/27/2001 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Fred S. Rayant | McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in death) | a. Metastatic Nonsmall cell lung cancer | 3months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. tf yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☑Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Julie R Brahmer MD | D0051770 | August 24 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julie R Brahmer MD Johns Hopkins Hospital, Baltimore MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | Geneva D Sparks |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27216

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Madeline | | Gallop | Aug 22 2001 | 3:40P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Hospital | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-34-7683 | 1☐M 2☑F | 66 Yrs. | | | 4 4 35 | West Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3110 E. Federal street | 21213 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | N/A | Social Worker | Social Work |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surname) |
|---|---|
| James T. Smith | Clara Mae Goodall |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Steven Gallop | 3110 E. Federal St. Balto. MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Woodlawn Cemetery | 8-28-01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Patricia Betts | Betts Funeral Home 1129 N. Caroline St Baltimore, Maryland 21213 |

**To Be Completed by Funeral Director**

Gallop Madeline

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified and sign.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 3 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Renal failure | 1 month |
| | Due to (or as a consequence of): c. Coronary Artery Disease | 5 years |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☑No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☑No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☑Yes 2☐No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Attending Physician | 053642 | Aug 22 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
X/A0240u 3007 E Northern Parkway Bal. MD 21214

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ Penny B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27217

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Alice June Ghent
2. Date of Death (Month, Day, Year): August 16, 2001
3. Time of Death: 12:40PM
4a. Facility Name *(If not institution, give street and number)*: 7915 24th Avenue
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 214-14-5160
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 29, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7915 24th Avenue
10f. Zip Code: 20783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Walter L. Pierce
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice E. Taylor

19a. Informant's Name/Relationship *(Type, Print)*: Helen Julie Ghent-Paolucci/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19424 Transhire Rd. Gaithersburg MD 20886

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Crematory
Date: 8-19-2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dayo Mallard
22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Brain Metasteses — Months
Due to (or as a consequence of):
Pulmonary neoplasm — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Norton Elson MD
29c. License number: D20362
29d. Date signed *(Month, Day, Year)*: August 23, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORTON ELSON 6525 Belcrest Rd Hyattsville MD 20782

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 27 2001
32. Registrar's Signature: D. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item20b PER FH G798

# Certificate of Death

08/27/01RR Reg. No. 2001 27218

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Alice Marie Holden

2. Date of Death: Month: August Day: 23 Year: 2001

3. Time of Death: 2024 M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore, Maryland

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 213-98-8137

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10 1964

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1127 Furnace Road

10f. Zip Code: 21090

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hostess

16b. Kind of Business/Industry: Restaurant

17. Father's Nama (First, Middle, Last): Lawrence Anthony Holden

18. Mother's Name (First, Middle, Maiden Surname): Helen Marie Cochran

19a. Informant's Name/Relationship (Type, Print): Lawrence Anthony Holden (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1127 Furnace Road, Linthicum, Md. 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 27 8/~~28~~/2001

20c. Location - City or Town, Stata: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Entar tha disaase, or complications that ceused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Intarval Between Onsat and Daath

Immediata Causa (Final disease or condition resulting in death)

a. Staphylococcus Aureus Meningitis — 5days

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in daath) Last

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

IF FEMALE:

23b. Was decedant pregnant in tha past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnancy 4☐ Pragnant at tima of death 5☐ Othar (specify) 9☐ Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Endocarditis

Intravenous Drug Abuse

23e. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☒ No

25. Was casa refarrad to medical examinar? 1☐ Yes 2☒ No

28. Placa of Death (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Residanca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarminad

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Cartifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to the causa(s) and manner as stated. 2☐ **Madical Examinar:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha ceuse(s) and manner stated.

29b. Signature and title of cartifier: Morgan McCullough MD Resident Physician

29c. License number: P14292

29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed causa of daath (Itam 23a) (Typa, Print): Morgan McCullough, MD University of Maryland Hospital Baltimore, MD 21201

**State Registrar**

31. Data filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27219

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Avery Miranda Harrington

2. Date of Death (Month, Day, Year): AUGUST 16 2001

3. Time of Death: 5:50 PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number:

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. 9

8. Date of Birth (Month, Day, Year): 8/16/01

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5202 Redhill Way

10f. Zip Code: 21237

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4or 5+): None

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): John Robert Harrington

18. Mother's Name (First, Middle, Maiden Surname): Shellish P Johnson

19a. Informant's Name/Relationship (Type, Print): G.B.M.C. PATHOLOGY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 N. CHARLES ST. TOWSON, MD. 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY

Date: 8/21/2001

20c. Location - City or Town, State: BALTO. CITY, MD

21. Signature of Funeral Service Licensee: William C. Lewis III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO, MD 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. extreme prematurity — Approximate Interval Between Onset and Death: 9 minutes

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kamal Hamod MD

29c. License number: D22188

29d. Data signed (Month, Day, Year): 8/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kamal Hamod MD 10753 Falls Road, Suite 345, Lutherville, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27220

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tom Huffstetler
2. Date of Death Month: Aug Day: 23 Year: 2001
3. Time of Death: 1105
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: AA

**Funeral Director**

5. Social Security Number: 249-86-4980
6. Sex: 1 XX M 2 F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/3/1951
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 Yes 2 XX No
10e. Street and Number: Taynare Cove Road
10f. Zip Code: 21060
10g. Citizen of What Country?: USA

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Painter

17. Father's Name (First, Middle, Last): William D. Huffstetler
18. Mother's Name (First, Middle, Maiden Surname): Mary G. Henson

19a. Informant's Name/Relationship (Type, Print): William T. Huffstetler
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1019 Sunnybrook Drive, Glen Burnie, MD 21060

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Pk.
Date: 8/27/01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, PA
426 Crain Hwy., SW, Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Ventricular Fibrillation
Due to (or as a consequence of): b. Arteriosclerotic Heart Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No
28. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Jones Deputy MD
29c. License number: D06054
29d. Date signed (Month, Day, Year): 8/23/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America Ct. 21035

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: George D Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RR

RR 2

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27221

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY LOUISE HOWARD

2. Date of Death: Month Aug Day 25 Year 2001

3. Time of Death: 7:40 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 216-42-4534

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): MAY 30, 1927

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: MILLERSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 658 COG COURT

10f. Zip Code: 21108

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM JANUARY

18. Mother's Name (First, Middle, Maiden Surname): ANNA AMELING

19a. Informant's Name/Relationship (Type, Print): NANCI CURCIO (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1109 MAGNOLIA STREET, NEW SMYRNA, FLORIDA 32168

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHURCH OF GOD CEMETERY

Date: 8/28/2001

20c. Location - City or Town, State: GAMBRILLS, MD.

21. Signature of Funeral Service Licensee: [signature] MO1220

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Sepsis | 10 days |
| Due to (or as a consequence of): b. | Acute Myocardial Infarction | 10 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] House Officer

29c. License number: D53642

29d. Date signed (Month, Day, Year): Aug 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 301 Hospital Dr. Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carl Lee Holston, Sr.
CJ
01-4783-005

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27222

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CARL LEE HOLSTON, SR.
2. Date of Death: Month August, Day 20, Year 2001
3. Time of Death: 08:15 A.M.
4a. Facility Name (If not institution, give street and number): 808 Woodlynn Road
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 231-18-5925
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug. 28, 1921
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County- Essex
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 808 Woodlynn Rd.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No. If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No. Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. | College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Woodworking Mechanic
16b. Kind of Business/Industry: U.S. Coast Guard

17. Father's Name (First, Middle, Last): Peyton Marion Holston
18. Mother's Name (First, Middle, Maiden Surname): Rose Thacker

19a. Informant's Name/Relationship (Type, Print): Carl L. Holston,Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 Huntington Way Belair, Md. 21215

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery
Date: 8-24-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. F. Lassahn
22. Name and Address of Facility: E. F. Lassahn Funeral Home, 11750 Belair Rd. Kingsville, Md. 21087

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrythmia
Due to (or as a consequence of):
b. Hypertensive Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Primary Thrombocythemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 8 X Other (Specify) Scene

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. [illegible]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACKSON, TIPU, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 205.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-4807-005
B.K.S
DAVID HARRIS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27223

UNPENDED 082801:ITEMS#23a,b,ptII,27 per ME G798 ss

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAVID HARRIS
2. Date of Death Month AUG. Day 21, Year 2001
3. Time of Death: 0111 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 219-72-7092
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-30-1959
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3619 N. Rogers Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ASSISTANT ENGINEER
16b. Kind of Business/Industry: STATE HIGHWAY ADMINSTRATION

17. Father's Name (First, Middle, Last): WALTER HARRIS
18. Mother's Name (First, Middle, Maiden Surname): MARIE GODDLY

19a. Informent's Name/Relationship (Type, Print): ALICE ROBINSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3619 N. ROGERS AVE, BALTO. MD 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 8-28-01
20c. Location - City or Town, State: OWING MILLS, MD

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
b. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUG. 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Apple M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27224

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Andrew L. Johnson | 8 / 23 / 2001 | 10:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UMMS, University of Maryland | Baltimore, MD | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-18-9007 | 1 [X] M 2 [ ] F | 77 Yrs. | | | September 23, 1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | | Baltimore | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 340 S Woodyear Street | 21223 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Nursing Assistant | Health Care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Andrew O. Johnson | Eva E. Weinreich |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gertrude A. Johnson/ Spouse | 340 S. Woodyear St. Baltimore, MD 21223 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Baltimore National Cemetery | August 27, 2001 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Bryan Freeman | Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. acute myocardial infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. coronary artery disease | 10 yrs. |
| | Due to (or as a consequence of): c. | |
| | Due to (or as e consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

| 29b. Signatura and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| Sharon Balansa MD | D0055157 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon Balansa MD, 10 N. Greene St. Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | Jenna G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

1 of 1

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27225

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lillian May Krauss

2. Date of Death (Month, Day, Year): Aug. 25, 2001

3. Time of Death: 9:20AM

4a. Facility Name (If not Institution, give street and number): 719 Maiden Choice Lane Apt. BRT 27

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-12-4019

6. Sex: 1☐ M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25, 2001

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 719 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carl Emmett Nelson

18. Mother's Name (First, Middle, Maiden Surname): Annie Nelson

19a. Informant's Name/Relationship (Type, Print): Samuel R. Krauss, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane Apt. BRT 27 Catonsville, MD. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park | Date: 8-27-01

20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Peter Rebmann

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lymphoma — 10 years
Due to (or as a consequence of):
b. Emphysema — 5 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Coronary Artery Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sapna Kuehl

29c. License number: D56473

29d. Date signed (Month, Day, Year): Aug 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sapna Kuehl, M.D. ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-4880-005
jhm
LOUISA FINK
KAHN UNPENDED 101001:ITEMS#23a,27,28a-f per ME G800 ss

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27226

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Louisa F. Kahn | AUGUST 25, 2001 | 13:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1817 THORNTON RIDGE ROAD | THORNLEIGH | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-42-7096 | 1☐ M 2☒ F | 56 Yrs. | | | 11-13-1944 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Towson | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1817 Thornton Ridge Road | 21204 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George S. Fink | Helen Freitag |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Mortimer Kahn (Husband) | 1817 Thornton Ridge Road, Towson, Md. 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Hilltop Service Corp. | 8-27-01 | Towson, Maryland 21204 |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wallace S. Brooks, Jr. | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
a. ALCOHOL AND CHLORDIAZEPOXIDE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☑ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how Injury occurred |
|---|---|---|---|---|
| 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined | Found: 8-25-01 | Found: 1:27p M | 1☐ Yes 2☒ No | Unknown |

| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |
|---|---|
| Residence | 1817 Thornton Ridge Rd., Balto., MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner es ststed.
2☒ **Medical Examiner:** On the basis of examination snd/or Investigation, in my opinion, death occurred st the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature end title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Marjorie A. Turell MD | OCME | AUGUST 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANN A. KOROL 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27227

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bok Rye Kim

2. Date of Death Month: August Day: 25 Year: 2001

3. Time of Death: 12:50 PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-11-4651

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 12 1913

9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2108 Folkstone Rd.

10f. Zip Code: 21093

10g. Citizen of What Country? Korea

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Korean

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Mr. Yong Kim/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2108 Folkstone Rd. Timonium, Md. 21093

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Cem Date: 8-27-01

20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: Ruth I. Lewis

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC BRAIN INJURY — Approximate Interval Between Onset and Death: 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIAC ARRHYTHMIA — 1 DAY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AT 245846 BZ

29d. Date signed (Month, Day, Year): August 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON JENKINS, MD UNION MEMORIAL HOSPITAL 201 E. UNIVERSITY PKWY BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: D. Sparks

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27228

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| Jyri | Kork | August 22, 2001 | 8:30 pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 117 Julian Ct. | Greenbelt | Prince Georges |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 153-26-2218 | 1 ☒ M 2 ☐ F | 73 Yrs. | | | November 13, 1927 | Estonia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince Georges | GreenBelt | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 117 Julian Ct. | 20770 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 6 | Engineer | Aerospace |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| Jyri | Kork | Valvi | Loigu |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ann Kork-wife | 117 Julian Ct., Greenbelt, MD 20770 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hilltop Service Corporation | 8/27/01 | Towson, MD |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ [signature] | William G. Dau | Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ARTHEROSCLEROTIC HEART DISEASE | 20 YEARS |
| Due to (or as a consequence of): | b. CEREBROVASCULAR DISEASE | 20 YEARS |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERCHOLESTEROLEMIA

PROSTATE CANCER

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To tha best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D46834 | 08-24-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR RUTH LOPEZ - 7525 Greenway Ctr Dr #113 Greenbelt md.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ [signature] Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 17 Rev 1/2001

ORIGINAL

01-4827-033
crn
Kenneth Karmilowicz

Amend IteM#9,10 perFHG799 9/7/01 EW

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27229

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Kenneth Karmilowicz

2. Date of Death: Month: August; Day: 22; Year: 2001

3. Time of Death: 9:11 P.M.

4a. Facility Name (If not institution, give street and number): Route 301 South at Central Avenue

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 217-72-9456

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 37 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/19/64 ~~AUG. 19, 1964~~

9. Birthplace (State or Foreign Country): ~~Virginia~~ MD

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 12314 Sea Pearl Court

10f. Zip Code: 20708

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Roofing

16b. Kind of Business/Industry: Home Improvement

17. Father's Name (First, Middle, Last): Bernard F. Karmilowicz

18. Mother's Name (First, Middle, Maiden Surname): Virginia Piskorik

19a. Informant's Name/Relationship (Type, Print): Bernard Karmilowicz - father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3287 Sudlersville South, Laurel, Md. 20724

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crm. Date: 8/27/01

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: Deloris M Davis

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Md. 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? ~~1☒Yes~~ 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year): 8/22/01

28b. Time of Injury: 9:00 P M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: PASSENGER involved in auto accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street

28f. Location (Street and Number or Rural Route Number, City or Town, State): 301 SOUTH/CENTRAL AVENUE BOWIE, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. [illegible]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27230

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hersel Thomas Meadows

2. Date of Death Month Day Year: AUGUST 20 2001

3. Time of Death: 12:30 P.M.

4a. Facility Name (If not institution, give street and number): 3902 FAIRHAVEN AVE.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 236-22-7465

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 7, 1923

9. Birthplace (State or Foreign Country): W. Va.

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒Yas 2☐No

10e. Street and Number: 3902 Fairhaven Avenue

10f. Zip Code: 21226

10g. Citizan of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Giva Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:

14. Rece - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): Environmental Chemical Operator

16b. Kind of Business/Industry: FMC, Inc.

17. Fether's Name (First, Middle, Last): Pearl Thomas

18. Mother's Name (First, Middle, Meiden Sumame): Finnie Evelyn Pennington

19a. Informant's Name/Ralationship (Type, Print): Sarah C. Leonard (Daughter)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 442 Ritford Drive, Severna Park, Md. 21146

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadowridge Mem. Pk.

Date: 8/25/2001

20c. Location - City or Town, Stata: Elkridge, Maryland

21. Signefura of Funaral Service Licensee: Kevin E Ecker

22. Nama and Addrass of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximate Interval Between Onsat and Deeth

Immediata Cause (Final disease or condition rasulting in daath)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Diseese or injury that initiated events rasulting in daath) Last

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yas, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnent at tima of daath 5☐Othar (specify) 9☐Unknown

23d. Data of dalivery Month Day Year

Part II. **Other significant conditions** contributing to death buf not resulting in tha underlying causa givan in Part I.

Hypertension

Pulmonary Emphysema

23a. Did tobecco use contributa to tha causa of daath? 1☐Yas 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings availabla prior to completion of causa of daath? 1☐Yas 2☒No

25. Was case refarred to medical examiner? 1☒Yes 2☐No

28. Place of Daath (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Othar: 4☐Nursing Homa 5☒Residance 6☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Colvin Carter MD

29c. License number: D01459

29d. Data signed (Month, Day, Year): Aug. 21, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Colvin Carter 4710 Pennington Ave Baltimore, Md. 21226

**State Registrar**

31. Data filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signatura: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

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**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #23a,b&cPER PHY G798 8/ib **Certificate of Death**

Reg. No. 2001 27231

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Thomas B. McCrory

2. Dete of Deeth: Month 8 Dey 05 Yeer 01

3. Time of Death: 5:30PM

4e. Feciity Neme (If not institution, give street end number): ST. ELIZABETHS N.H.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Deeth: BALTIMORE CITY.

**Funeral Director**

5. Socie! Security Number: 212-01-5712

6. Sex: 1☒M 2☐F

7. Age (In yrs. iest birthdey): 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 11-21-20

9. Birthpiece (Stete or Foreign Country): NEW YORK

Usuei Residence of Decedent

10e. Stete: MD. 10b. County: BALTIMORE 10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 52 OLD GRANARY CT. 10f. Zip Code: 21228 10g. Citizen of Whet Country? U.S.A.

11. Marital Stetus: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - Americen Indien, Bieck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): UNIT MANAGER

16b. Kind of Business/Industry: T.V. PRODUCTION

17. Fether's Neme (First, Middle, Last): HARRY McCRORY SR.

18. Mother's Neme (First, Middle, Meiden Surneme): ELIZABETH MAHER

19e. Informent's Neme/Reietionship (Type, Print): HARRY McCRORY JR.

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 52 OLD GRANARY CT. CATONSVILLE MD 21228

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): GLEN HAVEN MEM. Dete: AUG 10 2001

20c. Locetion - City or Town, Stete: A.A. Co MD.

21. Signeture of Funerel Service Licensee: Thomas J. Skarda J.

22. Neme end Address of Feciity: SKARDA F.H. 2529 HUDSON ST. BALTO. MD. 21224

**Physician /Medical Examiner**

23e. Pert I. Enter the diseese, or compiicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feiiure. List only one ceuse on eech line.

Approximete Interveil Between Onset end Deeth

Immediete Ceuse (Finei diseese or condition resulting in deeth): e. Arteriosclerotic Disease. ~~End Stage Dementia~~

Due to (or as a consequence of): END STAGE DEMENTIA

Sequentiiy list conditions, if eny, ieeding to immediete cause. Enter Underiying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. ~~Anoperia~~

Due to (or es e consequence of): ANOREXIA

c. ~~Lung Mass.~~

Due to (or es e consequence of):

d. LUNG MASS

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underiying cause given in Pert I.: H/o Abdominal aortic Aneurysm Repair

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveilable prior to compietion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred:

28e. Ptece of Injury - At home, ferm, street, fectory, offica buiiding, etc. (Specify):

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner as stated. 2☐Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end titie of certifier: Herman Brecher M.D.

29c. License number: D01317

29d. Dete signed (Month, Dey, Yeer): 8-7-01.

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Herman Brecher, M.D 700 Geipe Rd. Baltimore Md 21228

**State Registrar**

31. Dete filed (Month, Dey, Yeer): AUG 27 2001

32. Registrer's Signeture: Geneva D Sparks

DHMH 16 Rev 6/95

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

THOMAS B. McCRORY

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27232

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Linda Moore

2. Date of Death: Month Aug Day 21 Year 2001

3. Time of Death: 0723AM

4a. Facility Name (If not institution, give street and number): Bon Secour Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: UNKNOWN

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 10, 1951

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 1723 Ruxton Avenue

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Accountant

18b. Kind of Business/Industry: I H S

17. Father's Name (First, Middle, Last): Bernis Moore

18. Mother's Name (First, Middle, Maiden Surname): Lizzie M. Fryar

19a. Informant's Name/Relationship (Type, Print): Lizzie M. Moore-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3000 Poplar Terrace Baltimore, MD 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem. Date: 8/27/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Grant a Miller

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: a. less than a moment b. several years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular disease

Ventricular septal defect

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): —

28b. Time of Injury: — M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred: —

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): —

28f. Location (Street and Number or Rural Route Number, City or Town, State): —

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Homayoon Moghbeli, M.D.

29c. License number: D17720

29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HOMAYOON MOGHBELI, 2000 W. Balto. ST. BALTO. MD, 21223

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

amend item 18 PER FH C800 10/01/01 JH
AMEND ITEMS 2&19a PER PHY G799 9/27/01 JH
AMEND ITEMS #4a&26 PER PHY G799 9/27/01 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27233

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Owen B. Monroe, Jr.

2. Date of Death — Month: August; Day: ~~12~~ 16; Year: 2001

3. Time of Death: 11:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: MEDSTAR 3225 ESTHER PLACE

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 408-48-4641

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: Jan. 2, 1931

9. Birthplace *(State or Foreign Country)*: TN

Usual Residence of Decedent

10a. Stata: NC

10b. County: Cumberland

10c. City, Town or Location: FAyetteville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 3513 Java Drive

10f. Zip Code: 28311

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No — If Yas, Giva Yaar or Datas: USAF Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education *(Specify only highast greda completed)*: Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Flight Engineer

16b. Kind of Business/Industry: US Airforce

17. Fathar's Nama *(First, Middla, Last)*: Owen B. Monroe Sr.

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: ~~Unknown~~ PRUDIE MARTIN

19a. Informant's Name/Ralationship *(Type, Print)*: Eda Bullard /DAUGHTER

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 3225 Esther Pl. Baltimore MD 21224

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from Stata 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Anatomic Gift Foundation — Data: 8/17/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funaral Service Licensee: ▶ [signature]

22. Nama and Address of Facility: Anatomic Gift Foundation 13448 Baltimor Ave. Laurel MD 20707

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immedieta Causa (Final disaasa or condition resulting in death): a. Liposarcoma — 3 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immedieta causa. Entar Underlying Causa (Disaase or Injury that initiated events rasulting in death) Last:

b. Dua to (or as a consequence of):

c. Dua to (or as a consequanca of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☐ No

26. Placa of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ ~~Rasidanca~~ 6☒ Othar *(Specify)* DAUGHTER"S HOUSE

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha time, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigetion, in my opinion, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar stated.

29b. Signatura and titla of certifiar: ▶ Conrad May M.D.

29c. Licansa number: D32186

29d. Date signed *(Month, Day, Yaar)*: August 22, 2001

30. Nama and address of person who completad cause of death (Item 23a) (Type, Print): Conrad May, M.D. 10 N. Greene St., Baltimore, MD 21201

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: AUG 27 2001

32. Registrar's Signatura: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

#1
4a
26

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27234

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAVIS Barton McCarn

2. Date of Death Month: August Day: 16 Year: 2001

3. Time of Death: 0745 AM

4a. Facility Name (If not institution, give street and number): 6455 Windermere Circle

4b. City, Town, or Location of Death: North Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 336-20-2497

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): October 15, 1928

9. Birthplace (State or Foreign Country): IL

Usual Residence of Decedent

10a. State: MD

10b. County: montgomery

10c. City, Town or Location: North Bethesda

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6455 Windermere Circle

10f. Zip Code: 20852

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No USAF

If Yes, Give Year or Dates: 1952-1970

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Specialist

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): DAVIS Glessner McCarn

18. Mother's Name (First, Middle, Maiden Surname): Ruth O'Brien

19a. Informant's Name/Relationship (Type, Print): Grace McCarn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6455 Windermere Cir. N. Bethesda MD 20852

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation Date: 8/16/01

20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee: ▶ B. O A

22. Name and Address of Facility: Anatomic Gift Foundation 13448 Baltimore Ave Laurel MD 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Small cell Lung cancer — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypercalcemia

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury M

26c. Injury at Work? 1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D43083

29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George A Soros MD 9707 Medical Center Dr #300 Rockville MD 20850

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: ▶ [signature] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27235

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Irma M. Mitchell

2. Date of Death: Month 8 Day 24 Year 01

3. Time of Death: 1 20 pm

4a. Facility Name (If not institution, give street and number): Edenwald

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-44-8295

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04/09/1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 800 Southerly Road

10f. Zip Code: 21286

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk-Stenographer

16b. Kind of Business/Industry: United States Dept. of Agriculture

17. Father's Name (First, Middle, Last): Edward C. Mackenroth

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Wolfram

19a. Informant's Name/Relationship (Type, Print): Stephanie Coppola/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1617 Park Ave. Baltimore, Maryland 21217-4306

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grdns.

Date: 08/27/01

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Stephen D. Coster M01122

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction — 1d

Due to (or as a consequence of):
b. chronic obstructive pulmonary disease — 10yr.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. atherosclerotic disease — 10yr

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: physician

29c. License number: D29769

29d. Date signed (Month, Day, Year): 8/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcelina P. Albuerne MD 516 N. Rolling Rd Balto Md 21228

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Irma Mitchell

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 27236

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES WILLIAM MAXWELL
2. Date of Death (Month, Day, Year): 08 25 01
3. Time of Death: 6:45 PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF GLEN BURNIE
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 216-22-0810
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 6, 1926
9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6216 N. ORCHARD ROAD
10f. Zip Code: 21090
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EDITOR
16b. Kind of Business/Industry: NEWSPAPER

17. Father's Name (First, Middle, Last): JAMES ACKLEY MAXWELL
18. Mother's Name (First, Middle, Maiden Surname): RETA HAZEL NICKERSON

19a. Informant's Name/Relationship (Type, Print): MS. RETA MAXWELL (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6216 N. ORCHARD ROAD, LINTHICUM, MARYLAND 21090

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC. Date: 8/27/2001
20c. Location - City or Town, State: STEVENSVILLE, MD.
21. Signature of Funeral Service Licensee: Stephen A. Singleton
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — 1 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA
PNEUMONIA
SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: D55506
29d. Date signed (Month, Day, Year): 08/25/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FER EREN, M.D. 3721 Potee Street Baltimore, Maryland 21225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27237

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| KATHERINE PAPPAS | August 22 01 | 23:24 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-30-9285 | 1☐M 2☒F | 77 Yrs. | | | August 20, 1924 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | n/a | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5612 Greenhill Ave. | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | n/a | Bank Teller | Banking |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Theodorakos | Stella |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Estelle Nicolet-daughter | 5616 Greenhill Ave., Baltimore, MD 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Oak Lawn Cemetery | 8/25/01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ William G. Dau | Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Subarachnoid Hemmorrhage | 72 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ PG-YI | RES000 | August 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ARUN MATHEWS, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN Blvd, Baltimore MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27238

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lorraine Putens
2. Date of Death (Month, Day, Year): August 24, 2001
3. Time of Death: 9:40 am
4a. Facility Name (If not institution, give street and number): Oak Crest Care Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-24-8936
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 1, 1917
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8810 walther Blvd., Trevor Pl. Apt. 3310
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civilian Employee
16b. Kind of Business/Industry: U. S. Government

17. Father's Name (First, Middle, Last): Howard Putens
18. Mother's Name (First, Middle, Maiden Surname): Mary Unger

19a. Informant's Name/Relationship (Type, Print): Mary Raphel-friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8451 Pleasant Plains Rd., Towson, MD 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park
Date: 8/27/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: William G. Dau
22. Name and Address of Facility: Leonard J. Ruck Funeral Home, inc. 5305 Harford Rd., Baltimore, MD 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small bowel lymphoma — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease, Pancreatic Cancer, Uterine Cancer, Cerebral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan Weiner MD
29c. License number: D34941
29d. Date signed (Month, Day, Year): August 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stephen Petrusik, Sr.
CJ
01-4800-510

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27239

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Stephen Andrew Petrusik, Sr.
2. Date of Death: Month: August Day: 21 Year: 2001
3. Time of Death: 01:52 P.M.
4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-52-2591
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 20, 1947
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 121 Ridge Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equiptment Mechanic
16b. Kind of Business/Industry: Mechanic

17. Father's Name (First, Middle, Last): Andy Petrusik
18. Mother's Name (First, Middle, Maiden Surname): Thelma Norris

19a. Informant's Name/Relationship (Type, Print): Susan A. Petrusik, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Ridge Ave. Lansdowne, MD. 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery
Date: 8-24-01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Stan P. Stukas
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic Cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27240

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edith Peacock

2. Date of Death: Month Aug Day 22 Year 2001

3. Time of Death: 1122

4a. Facility Name (If not institution, give street and number): 291 Red Clay Rd #202

4b. City, Town, or Location of Death: Laurel

4c. County of Death: AA

**Funeral Director**

5. Social Security Number: 518-30-7733

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 27, 1927

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD.

10b. County: Anne Arundel

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 291 Red Clay Road # 202

10f. Zip Code: 20724

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Richard Peacock - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 291 Red Clay Road, #202, Laurel, Md. 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 8/28/01

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Silvia Davis

22. Name and Address of Facility: Fleck Funeral Home, 7601 Sandy Spring Road, Laurel, Md. 20707

**Physician /Medical Examiner**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones, MD Deputy

29c. License number: D 06054

29d. Date signed (Month, Day, Year): 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Bernice D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Medical Certification:**

RKD

01-4803-510

CLYDE

PARKS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27241

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Clyde W. Parks
2. Data of Death — Month: AUGUST Day: 21, Year: 2001
3. Time of Death: 5:30P.M.
4a. Facility Name (If not institution, give street and number): 3708 HAYWARD AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 244-22-4860
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-12-1924
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3708 Hayward Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired): Ironworker
16b. Kind of Business/Industry: Iron & Metal Co.

17. Father's Name (First, Middla, Last): Daniel Parks
18. Mother's Name (First, Middle, Maidan Surname): Margaret Redmond

19a. Informant's Name/Relationship (Type, Print): Jeanette Parks
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 3708 Hayward Ave. Baltimore, Md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or othar place): King Memorial Park — Date: 8/25/01
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funaral Service Licensee: Dale March
22. Name and Address of Facility: M. C. March Funeral Home, 4300 Wabash Avenue, Baltimore, MD 21215

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilura. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequenca of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence ot):
c.
Due to (or as a consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, tactory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner es stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Bruehl M.D.
29c. Licensa number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 22, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MARY LOUISE P. KOLAR, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #8 PER FH G799 9/17/01 JK

# Certificate of Death

Reg. No. 2001 27242

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine E. Rausch

2. Date of Death Month Day Year: Aug. 24, 2001

3. Time of Death: 6:25 AM

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Catonsville

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-16-1929

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-10-18 ~~Feb. 24, 2001~~

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2227 Christian Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Roscoe Yingling

18. Mother's Name (First, Middle, Maiden Surname): Mary Orndorf

19a. Informent's Name/Relationship (Type, Print): Mary Frantz, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 Cedarmere Rd. Owings Mills, MD. 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Loudon Park Cemetery

Date: 8-27-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Rebecca Rehmus MO1254

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 1month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction — 1month

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

26a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D52544

29d. Date signed (Month, Day, Year): Aug 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin Lee, M.D. 700 Geipe Rd #204, Catonsville MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27243

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROBERT ROYSTER

2. Date of Death: Month AUGUST Day 21 Year 2001

3. Time of Death: 1500

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

**Funeral Director**

5. Social Security Number: 228-40-5979

8. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2 23 39

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 2036 E. Baltimore Street

10f. Zip Code: 21231

10g. Citizen of What Country? U.S.A

11. Meritel Stetus: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 10

College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Chemical Company

17. Father's Name (First, Middle, Last): Robert Royster Sr.

18. Mother's Name (First, Middle, Maiden Surneme): Annie Oliver

19a. Informant's Neme/Relationship (Type, Print): Arcelia Royster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2036 E. Baltimore st. Balt. mD 21231

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. Zion Cemetery

Date: 8-25-01

20c. Location - City or Town, State: Balto. Maryland

21. Signeture of Funerel Service Licensee: ▶ Patricia Betts

22. Neme and Address of Facility: BETTS Funeral Home 1129 N. Caroline St. Balto mD 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode ot dying, such es cardiec or respiratory errest, ahock, or heart taiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Causa (Final diseese or condition resulting in death)

a. METASTATIC LUNG CANCER — 2 YEARS

Due to (or es a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

ACUTE RENAL FAILURE

23b. Did tobecco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medicel exeminer? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ JAbraham MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): AUGUST 21, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JACOB ABRAHAM THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTIMORE, MARYLAND 21287

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: ▶ Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27244

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| HARRY JACKSON RUFFIN, JR. | AUGUST 24 2001 | 8:55 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 230-22-1632 | 1 [X] M 2 [ ] F | 72 Yrs. | | | OCT. 24, 1928 | VA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTO. | OWINGS MILLS | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 41 PITTSTON CIRCLE | 21117 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | CONSTRUCTION | BUILDING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HARRY J. RUFFIN, SR. | DORA WILLIAMS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ATLAY RUFFIN/WIFE | 1236 DIVISION ST., BALTIMORE, MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MT. ZION | 8/30/2001 | BALTO., MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| James A. Morton | JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. hyperkalemia | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Chronic Renal failure | 2 year |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Hefner MD | RES 000 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jonathan Hefner MD Sinai Hospital Balto, MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Harry Ruffin
RR
RE 3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27245

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Randi B. Rushing | August 20, 2001 | 5:00 am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 262.58.1572 | 1☐M 2☒F | 72 Yrs. | | | Aug. 12, 1929 | Norway |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Greenbelt | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7709 Ora Court | 20770 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Maitre de Petite Marmite | Restuarant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Ole Martin Buran | Eline Brustad |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James L. Rushing/Son | 7709 Ora Court Greenbelt, MD 20770 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Baltimore Washington | 8/21/01 | Laurel, MD |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 48 hrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Parathyroid Cancer | 1 year |
| | c. Due to (or as a consequence of): Coronary Artery Disease | 5 years |
| | d. Due to (or as a consequence of): Peripheral Vascular Disease | 3 years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to tha cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] M.D | D43772 | August 20, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RASAQ ABU M.D. 6201 GREENBELT ROAD, #M-14, COLLEGE PARK MD. 20740.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ [signature] D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-4838-510
UNK 01-221
ASP
KAJALI SAMATEH

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 2001 27246

# Certificate of Death 08/27/01 Reg. No. RR

Amend Item 20b PER FH 798 8

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| KA JALI SAMATEH | | | AUGUST 23 2001 | 2345 |
| 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of Death | 4c. County of Death | |
| 2800 BLK INDIAN DRIVE | | BALTIMORE | N/A | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-43-5107 | 1 [X] M 2 [ ] F | 40 Yrs. | | | FEBRUARY 17, 1961 | THE GAMBIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1914 EUTAW PLACE APT. B | 21217 | THE GAMBIA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes: | 1 [ ] Yes 2 [X] No Specify: | Specify: BLACK |

| 15. Decedent's Educetion (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 years of College | TEACHER | GAMBIA PUBLIC SCHOOLS |

| 17. Father's Neme (First, Middle, Last) | 18. Molher's Name (First, Middle, Maiden Surneme) |
|---|---|
| MBEMBA SAMATEH | FATOU DRAMMEH |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHER J. CUFFIE SAMATEH (WIFE) | 1914 EUTAW PLACE, APT. B, BALTIMORE MD 21217 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify) | BAKAU CEMETERY | 09/01/01 ~~08-31-2001~~ | THE GAMBIA, WEST AFRICA |

| 21. Signature of Funerel Service Licensee | 22. Name and Address of Facility |
|---|---|
| | JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

immediete Cause (Finel disease or condition resulting in death)
a. Shotgun Wound to Neck
Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Piece of Death (Check only one) |
|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined | 8/23/01 | 2253HR | 1 [ ] Yes 2 [X] No | Subject shot |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): grassy area

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2800 Block Indian Road Baltimore Maryland

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. King MD | O.C.M.E | AUGUST 24, 2001 |

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrer's Signeture |
|---|---|
| AUG 27 2001 | Geneva D Sparks |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 10

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM# 15 PR. F.H. G799 9-6-01 JAB

# Certificate of Death

Reg. No. 2001 27247

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| FLOYD GRIFFIN SUTHARD, JR. | AUGUST 24, 2001 | 12:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Daeth | 4c. County of Deeth |
|---|---|---|
| 810 ROSEMERE AVENUE | SILVER SPRING | MONTGOMERY |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthdey) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth (Month, Dey, Yeer) | 9. Birthptece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-18-2077 | XX M 2☐ F | 78 Yrs. | | | JUNE 04, 1923 | WASHINGTON, D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | MONTGOMERY | SILVER SPRING | 1☐ Yes XX No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 810 ROSEMERE AVENUE | 20904 | UNITED STATES OF AMERICA |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Rece - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced | XX Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes XX No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | Collega (1-4or 5+) | | |
| 3 | | SUPERVISOR | W.S.S.C. |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surneme) |
|---|---|
| FLOYD G. SUTHARD, SR. | GRACE G. HOBBS |

| 19a. Informant's Neme/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| DARLENE POLLARD (DAUGHTER) | 1105 WARES CHAPEL ROAD; WASHINGTON, NORTH CAROLINA 27889 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| XX Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | NATIONAL MEMORIAL PARK | AUG. 28, 2001 | FALLS CHURCH, VIRGINIA |

| 21. Signature of Funeral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| ▶ | HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891 |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Itsm 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daeth. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on eech line.

| | | Approximata Interval Betwaen Onsat and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in daath) | a. Chronic Obstructive Pulmonary Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last | Due to (or as a consequence of): b. Coronary Artery Disease | |
| | Due to (or as a consequance of): c. Atrial Fibrilation | |
| | Due to (or es e consequanca of): d. Congestive Heart Failure | |

| tF FEMALE: 23b. Was decedent pregnent in tha past 12 months? | 23c. If yes, outcome of pregnency | 23d. Data of dalivary Month Day Year |
|---|---|---|
| 1☐ Yas 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the causa of death? | 24a. Was an autopsy performed? | 24b. Wara autopsy findings available prior to compiation of cause of deeth? |
|---|---|---|
| 1☐ Yas 2☐ No 3☒ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes case referred to medicat examiner? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 26c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturat 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) |
|---|---|
| | |

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, death occurrad et tha time, date and piece, end dua to the causa(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, end dua to the cause(s) and manner stated.

| 29b. Signatura and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| ▶ Ajay Reddy MD | D53691 | August 27, 2001 |

30. Nama and addrass of person who completed cause of daeth (Item 23a) (Typa, Print)

Ajay Reddy, M.D., 3411 Olanwood Court, Olney, Maryland 20832

To the Hospital or Attanding Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

#15

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27248

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Katherine R Simms

2. Date of Death: Month: August Day: 20 Year: 2001

3. Time of Death: 4:55PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 213-34-1627

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 30, 1936

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland 10b. County: Anne Arundel 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 622 Cromwell Street 10f. Zip Code: 21225 10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: E.I. Kane, Inc.

17. Father's Name (First, Middle, Last): John Porter

18. Mother's Name (First, Middle, Maiden Surname): Helen Regina Biddinger

19a. Informant's Name/Relationship (Type, Print): John E. Simms (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 622 Cromwell St., Baltimore, Md. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 8/23/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Kevin E Ecker

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia with Gram Negative Sepsis — 2 days

Due to (or as a consequence of):

b. Lung Cancer — 6 mos-

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Russell A DeLuca

29c. License number: D31551

29d. Date signed (Month, Day, Year): August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell A. DeLuca M.D. 1600 S. Crain Highway, Glen Burnie, Md. 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Geneva G Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27249

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charlotte Marie Stubler

2. Date of Death: Month AUG Day 20 Year 2001

3. Time of Death: 1509 M

4a. Facility Name (If not institution, give street and number): St. AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTO

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-01-2517

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Data of Birth (Month, Day, Year): Feb. 18, 1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1208 Poplar Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Server

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Henry Krabbe

18. Mother's Name (First, Middle, Maiden Surname): Lottie Dresbach

19a. Informent's Name/Relationship (Type, Print): Joyce Krabbe, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1208 Poplar Ave. Arbutus, MD. 21227

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Data: Aug. 22, 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Debra Robinson MO1254

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — ten days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Porta hepatitis tumor

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenneth Khandagle MD

29c. License number: P-15631

29d. Date signed (Month, Day, Year): August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Khandagle 900 Caton Avenue Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME STUBLER, CHARLOTTE

5

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27250

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Helen Staub
2. Date of Death (Month, Day, Year): Aug. 21, 2001
3. Time of Death: 12:30PM
4a. Facility Name (If not institution, give street and number): 2207 Smith Ave.
4b. City, Town, or Location of Death: Lansdowne
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-38-7062
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 29, 1942
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2207 Smith Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitorial
16b. Kind of Business/Industry: Cleaning

17. Father's Name (First, Middle, Last): Albert Joseph Fitzpatrick
18. Mother's Name (First, Middle, Maiden Surname): Nine Elizabeth Killian

19a. Informant's Name/Relationship (Type, Print): Bernard E. Staub, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 Smith Ave. Lansdowne, MD. 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 8-24-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Robert Robison
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 1 d
Due to (or as a consequence of):
b. Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Frederick Kuhn MD
29c. License number: 036336
29d. Date signed (Month, Day, Year): August 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Kuhn MD 3449 Williams Ave #300 Baltimore MD 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Lynn Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27251

William Edward Spencer
Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM EDWARD SPENCER
2. Date of Death: Month August Day 14 Year 2001
3. Time of Death: 8:10 pm
4a. Facility Name (If not institution, give street and number): 830 West 40th Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: UNKNOWN
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 28, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒Yes 2☐ No
10e. Street and Number: 830 West 40th Street
10f. Zip Code: 21211
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator
16b. Kind of Business/Industry: Baltimore Department of Education

17. Father's Name (First, Middle, Last): William Spencer
18. Mother's Name (First, Middle, Maiden Surname): Laura Price

19a. Informant's Name/Relationship (Type, Print): Carol L. Carter- Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Wytchwood Court Apt. 202 Balto. MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Pk.
Date: 8/16/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Chester B Wise
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE
Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T Cheikh
29c. License number: D14748
29d. Date signed (Month, Day, Year): August 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ISSAM E. CHEIKH, MD 201 E. UNIVERSITY PK BALTO, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Geneva G Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27252

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Michael Smith
2. Date of Death: Month 08 Day 25 Year 2001
3. Time of Death: 16:40
4a. Facility Name (If not institution, give street and number): Harbor Hospital, 3001 S. Hanover St
4b. City, Town, or Location of Death: Harbor Hospital
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 718-16-9071
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/15/1919
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 366 Mae Road
10f. Zip Code: 21061
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Clerk
16b. Kind of Business/Industry: Chessie System Railroads

17. Father's Name (First, Middle, Last): Joseph P. Smith
18. Mother's Name (First, Middle, Meiden Surname): Amelia Donati

19a. Informant's Name/Relationship (Type, Print): Anna Smith - Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 366 Mae Road, Glen Burnie, MD 21061

20a. Method of Disposition: 1XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: 8/28/01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink
22. Name and Address of Facility: FINK FUNERAL HOME, PA
426 Crain Hwy., SW, glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonia
Due to (or as a consequence of):
b. Sepsis 2° Urinary tract Infection
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. H/o Atrial Fibrillation & Congestive Heart Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypernatremia
Candidial UTI
Severe dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vinish Mohendal PGY1
29c. License number: P15584
29d. Date signed (Month, Day, Year): 08/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Vinish Mohendal, Harbor Hospital 3001 S. HANOVER ST.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature:

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RR 8+1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED 090402: ITEMS #23a, 25, 27, 28a per ME C811 ss — Certificate of Death — Reg. No. 2001 27253

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| RICHARD J. STONE | August 22 2001 | 1:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | ANNE ARUNDEL |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 216-03-8739 | XX 1 M 2 F | 53 Yrs. | | | 11/17/1948 | MD |

To Be Completed by Funeral Director

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MD | ANNE ARUNDEL | GLEN BURNIE | 1 Yes XX No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizan of What Country? |
|---|---|---|
| HENSON ROAD | | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) | 14. Race - Amarican Indian, Black, Whita, atc. |
|---|---|---|---|
| XX 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 XX No If Yes, Give Year or Dates: | 1 Yes XX 2 No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | DISABLED | NEVER WORKED |

| 17. Father's Nama (First, Middle, Last) | 18. Mothar's Name (First, Middla, Maidan Surname) |
|---|---|
| FRANCIS C. STONE, SR | CATHERINE G. SEHLHORST |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRANK C. STONE, JR. | 1303 NAGAHYDE ROAD, WESTMINSTER, MD 21157 |

| 20a. Method of Disposition | 20b. Place of Disposition (Nama of cemetary, crematory or other place) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| XX 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) | HOLY CROSS CEM. | 8/24/2001 | BALTIMORE, MD |

| 21. Signature of Funeral Service Licensee | LIC# | 22. Nama and Address of Facility |
|---|---|---|
| KELLY GREGORY FINK | M01148 | FINK FUNERAL HOME, PA 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 |

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. — Approximate Intarval Batween Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. ~~Hypoxic Encephalopathy~~ COMPLICATIONS OF ASPHYXIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): CHOKING ON BOLUS OF FOOD
b. ~~Status Epilepticus~~
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Othar (specify) 9 Unknown

23d. Date of delivary Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Down's Syndrome, Dysphagia, Hypothyroidism

23a. Did tobacco usa contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yas 2 X No

24b. Wara autopsy findings availabla prior to compliation of causa of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes ~~2 No~~

28. Placa of Death (Check only ona): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

27. Manner of Death: ~~1 Natural~~ 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

| 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| August 20, 01 | Unknown M | 1 Yas 2 X No | Subject choked on bolus of food |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Strast and Numbar or Rural Route Numbar, City or Town, State) |
|---|---|
| Almost Family- medical daycare facility | 6 S. Ritchie Hwy/ Crystal Ct,. Pasadena, MD |

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, daath occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to tha causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | D48006 | August 22, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOAITEY, 301 Hospital Dr., Glen Burnie, MD 21061

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001. | [signature] |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Stone Richard *

RR

RR 6

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27254

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Spence

2. Date of Death: Month August Day 12, Year 2001

3. Time of Death: 12:39 M

4a. Facility Name (If not institution, give street and number): Union Hospital of Cecil County

4b. City, Town, or Location of Death: EIKTON

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-26-3001

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 10, 1929

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Cecil

10c. City, Town or Location: Northeast

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 308 River Manor Dr.

10f. Zip Code: 21901

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Army WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Conductor

18b. Kind of Business/Industry: Conrail

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Jaime Muehsan/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 River Manor Dr. Northeast MD 21901

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation Date: 8/12/01

20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee: ▶ R J O

22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave Laurel MD 20707

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Metastatic Adenocarcinoma

Due to (or as a consequence of):

c. Primary Carcinoma of Lung

Due to (or as a consequence of):

d. Tobacco Abuse (history)

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No N.A.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): N.A.

28b. Time of Injury: N.A. M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No N.A.

28d. Describe how injury occurred: N.A.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N.A.

28f. Location (Street and Number or Rural Route Number, City or Town, State): N.A.

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Karen L. Carter MD

29c. License number: D57520

29d. Date signed (Month, Day, Year): 08/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen L. Carter MD, 322 E. Cecil Avenue, North East, MD 21901

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27255

SANTORO, FELIX

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Felix P. Santoro
2. Date of Death (Month, Day, Year): AUGUST 23, 2001
3. Time of Death: 2:53 P.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 218 28 8463
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 22, 1935
9. Birthplace (State or Foreign Country): Italy

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2124 Old Eastern Avenue
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
18b. Kind of Business/Industry: City Government

17. Father's Name (First, Middle, Last): Michael Santoro
18. Mother's Name (First, Middle, Maiden Surname): Giovina Soria

19a. Informant's Name/Relationship (Type, Print): Robert M. Heimbach (step-son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2124 Old Eastern Avenue, Baltimore, Maryland 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: Aug. 24, 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPOXIC CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. PULMONARY HYPERTENSION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Michael Pipkin
29c. License number: D005495
29d. Date signed (Month, Day, Year): AUGUST 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PIPKIN M.D. 4000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27256

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Shaw

2. Date of Death (Month, Day, Year): August 23 01

3. Time of Death: 2-20 Am

4a. Facility Name (If not institution, give street and number): Blue Point Nursing center

4b. City, Town, or Location of Death: Baltimore MD

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 216-34-6540

6. Sex: 1 ☐ M 2 ☐ F X

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 01-10-37

9. Birthplace (State or Foreign Country): NC

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1736 Thomas Avenue

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Disable

16b. Kind of Business/Industry: Disabled

17. Father's Name (First, Middle, Last): Willie E. Shaw

18. Mother's Neme (First, Middle, Maiden Surname): Augusta P. Robinson

19a. Informent's Name/Relationship (Type, Print): Betty L. Reed

19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4118 Oakford Avenue Baltimore, MD. 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Metro Crematory Dete: 08-27-2001

20c. Location - City or Town, Stete: Catonsville, MD

21. Signature of Funeral Servica Licensee: John B. Johnson

22. Neme and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH West 4300 Wabash Avenue

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onsat and Death

Immediete Ceuse (Final disease or condition resulting in deeth)

e. Atherosclerotic Cardiovascular disease — 4 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last

b. History of multiple recent Aspiration — 4 yr

Due to (or as a consequence of):

c. Pneumonia and cerebrovascular

Due to (or es a consequence of):

d. accident.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☒ No

25. Was cese referred to medicai exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner as steted. 2 ☐ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amatun N Naeem MD

29c. Licansa number: D 15503

29d. Date signed (Month, Day, Year): August, 23, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): AMATUN N NAEEM, 501 Dolphin St, Balto, MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: per P. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar 8-27-01 JAB AMND ITM#6 PR. F.H. G798

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27257

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| BIRDIE | ZELDA | SOLOMON | AUGUST | 23 | 2001 | 2:30A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-40-1707 | 1☐M 2☒F | 89 Yrs. | | | | | AUG 16, 1912 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | BALTIMORE | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3026 FALLSTAFF RD. | 21209 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | HOMEMAKER | OWN HOME |
| | 1 | | |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| AARON | ALBOM | IDA | GOODMAN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MAURICE SOLOMON (HUS.) | 3026 FALLSTAFF RD. BALTO.,MD 21209 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | ARLINGTON (CHIZUK AMUNO) | 8/24/01 | BALTIMORE, MD |

21. Signature of Funeral Service Licensee ▶ Burton H. Levinson

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Lung Cancer — 2 weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Myelodysplasia
Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death ☒1 Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ G Cl | D27730 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CARY COHEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204

**State Registrar**

31. Date filed (Month, Day, Year) AUG 27 2001 — 32. Registrar's Signature ▶ (pencil)

DHMH 17 Rev 1/2001

ORIGINAL

Solomon, Birdie

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 27258

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| JEROME | WALTER | SUROSKY | AUG | 23 | 2001 | 8:20A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTHWEST HOSPITAL CENTER | RANDALLSTOWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 220-07-8122 | 1☐M 2☐F X | 81 Yrs. | | | | | OCT 12 1919 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐Yes 2☐No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 POMONA WEST #5 | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐X Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☐X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | BUTCHER | MEATS |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ISRAEL | SUROSKY | DORA | ARONOFF |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| GOLDIE SUROSKY (WIFE) | 7 POMONA WEST #5 BALTIMORE, MD 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BETH EL MEM. PARK | 8/24/01 | RANDALLSTOWN, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): NECROTIC SACRAL ULCER | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE ALZHEIMERS

PARKINSONS

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Tasneem Lakhani | D28595 | 8/25/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALTO MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27259

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| WILLIAM | STIENING | | AUGUST 22 2001 | 12:00 P M |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| HARBOR HOSPITAL CENTER | BALTIMORE | | N/A | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-14-5167 | X M 2 F | 76 Yrs. | | | SEPT. 24, 1924 | PENNSYLVANIA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1 Yes X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 502 MAYO ROAD | 21061 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: 1965-1969 | 1 Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | CHAUFFEUR | NSA |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GEORGE W. STIENING | MARGARET KANE |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WESLEY G. STIENING (SON) | 502 MAYO ROAD, GLEN BURNIE, MARYLAND 21061 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | ARLINGTON NATIONAL CEMETERY 8/30/2001 | FORT MYER, VIRGINIA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Paul M. Hagan | SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | 10 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

CORONARY ARTERY DISEASE

ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one) — Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: X 1 Natural; 2 Accident; 3 Suicide; 4 Homicide; 5 Pending investigation; 6 Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A Shakil MD | RES 000 | AUGUST 22 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AMNA SHAKIL, 3001 S. HANOVER STREET, BALTIMORE MD 21225

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ Lenora B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27260

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VERNON SLUSHER
2. Date of Death (Month, Day, Year): Aug 19 2001
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: 1813 Palo Circle
4b. City, Town, or Location of Death: Arbutus
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 406-18-3713
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: Mar. 25, 1924
9. Birthplace *(State or Foraign Country)*: Kentucky

Usual Residanca of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1813 Palo Circle
10f. Zip Coda: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedent'a Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Army
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Henry Slusher
18. Mother's Name *(First, Middla, Maiden Sumama)*: Leona Hoskins

19a. Informant's Neme/Relationship *(Type, Print)*: Audrey Slusher - wife
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 1813 Palo Circle, Arbutus, Md. 21227

20e. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cametery, crematory or other placa)*: Meadowridge Memorial Park
Dete: 8/23/01
20c. Location - City or Town, State: Elkridge, Md.

21. Signatura of Funarel Service Licensee: ▶ Mark Marshall
22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert tailure. List only one cause on each line. — Approximate Intervel Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 3 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last
b. Due to (or es e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminar? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Wm C Waterfield MD
29c. License number: 024356
29d. Date signed *(Month, Day, Year)*: August 21, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Wm. C. WATERFIELD MD — St Agnes Cancer Center 900 Cathedral Ave Balto MD 21229

**State Registrar**

31. Date filed *(Month, Dey, Year)*: AUG 27 2001
32. Registrer's Signeture: ▶ Bernice D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #8 PER FH G798 8/27/01 JH

# Certificate of Death

Reg. No. 2001 27261

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Lillian Simms

2. Date of Death: Month Aug Day 23 Year 2001

3. Time of Death: 11 43 p

4a. Facility Name (If not institution, give street and number): Long Green Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

5. Social Security Number: 216-24-7049

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~MAY 12, 2001~~ 5-12-28

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1534 PENTWOOD ROAD

10f. Zip Code: 21239

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): WILL COOPER

18. Mother's Name (First, Middle, Maiden Surname): ROSE

19a. Informant's Name/Relationship (Type, Print): ABRAHAM SIMMS (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1534 PENTWOOD RD. BALTO, MD. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VETERANS CEM.

Date: AUG. 29, 2001

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Joint Disease

Bony Lytic lesion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D31464

29d. Date signed (Month, Day, Year): 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shoaib A. Hashmi, 821 N. Eutaw St Suite 304 Balt. MD 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27262

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nelson Leigh Tusing
2. Date of Death (Month, Day, Year): 08-21-2001
3. Time of Death: 2:05pm
4a. Facility Name (If not institution, give street and number): 1126 S. Main St.
4b. City, Town, or Location of Death: Hampstead
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 214-26-7138
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-15-1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1126 S. Main St.
10f. Zip Code: 21074
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 3/17/48 9/26/52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Federal Governmemt
17. Father's Name (First, Middle, Last): Thomas Franklin Tusing
18. Mother's Name (First, Middle, Maiden Surname): Bulah Mae Croft
19a. Informant's Name/Relationship (Type, Print): Anna R. Tusing/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1126 S. Main St. Hampstead Maryland 21074
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 8-22-01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Alan P. Ambrose
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Lansdowne MD 21227

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstonctive Pulmonary disease
Due to (or as a consequence of):
b. Esophageal cancer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Gastric cancer
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29e. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D51705
29d. Date signed (Month, Day, Year): 8-22-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. PANSUELA 4192 Malcolm Dr, Westminster, MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001
32. Registrar's Signature: Donna D Sparks

**Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Dwayne Thomas
CJ
01-4790-005

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#28b per ME G799 090501 SS

# Certificate of Death

Reg. No. 2001 27263

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dwayne Thomas

2. Date of Death: Month August, Day 20, Year 2001

3. Time of Death: 08:21 P.M.

4a. Facility Name (If not institution, give street and number): rear of 4312 Flint Hill Drive

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 069-58-0382

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 31 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05-27-70

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: NY

10b. County: NA

10c. City, Town or Location: Bronx

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2732 Dewey Avenue

10f. Zip Code: 10465

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Company

17. Father's Name (First, Middle, Last): Charles Kennedy

18. Mother's Name (First, Middle, Meiden Surneme): Alethia Thomas

19a. Informant's Name/Relationship (Type, Print): Alethia Thomas

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2732 Dewey Avenue Apt.#3C Bronx, N.Y. 10465

20a. Method ol Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Remove! from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place ol Disposition (Neme of cemetery, cremetory or other piece): Kensico Cemetery

Date: 08-29-2001

20c. Location - City or Town, State: Valhalla, NY

21. Signeture of Funerel Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or pomplicetions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE GUNSHOT WOUNDS

Due to (or es e consequence of):

Sequentiatly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy lindings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date ol Injury (Month, Dey Year): found 8/20/01

28b. Time of Injury: found 8:14pm ~~8/14/01P.M~~

28c. Injury at Work? 1 [X] Yes 2 [ ] No

28d. Describe how injury occurred: Subject shot

28e. Piece ol Injury - At home, ferm, street, factory, office building, etc. (Specify): Parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4312 Flint Hill Drive Owings Mills, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Theodore M. King M.D.

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): August 21, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27264

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ABE TAKEALL

2. Date of Death Month: August Day: 21 Year: 2001

3. Time of Death: 15:30 M

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 251-58-8225

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-08-1938

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3908 PENHURST AVE

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FORKLIFT

18b. Kind of Business/Industry: BOX FACTORY

17. Father's Name (First, Middle, Last): JUSHAU TAKEALL

18. Mother's Name (First, Middle, Maiden Surname): MAGELINE VICE

19a. Informant's Name/Relationship (Type, Print): MAGELINE TAKEALL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 129 VICE DR, ST. STEPHEN, SC 29479

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT ZION

Date: 08-25-01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Willie E Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO.MD 21207

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Lung Cancer — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Morales, DO

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jennifer A. Morales 2401 West Belvedere Avenue Baltimore, MD 21215

**State Registrar**

31. Date filed (Month, Day, Year): AUG 27 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Takeall, Abe

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27265

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Blanche | Williams | Aug. 23, 2001 | 7:30p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2423 Westport Street | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 259-42-5362 | 1☐M 2☒F | 92 Yrs. | | | 5/15/09 | GA. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2423 Westport St. | 21230 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th | N/A | Domestic | Other People Homes |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Williams | Susie |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley Flanigan | 2421 Westport St., Baltimore, MD 21230 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Mt. Zion Cemetery 8/28/01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Uremia — Approximate Interval Between Onset and Death: 8/13/01

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of): Withdrawal from Hemodialysis — 8/13/01

c. Due to (or as a consequence of): Failure to Thrive — 2/1/01

d. Due to (or as a consequence of): Stage IV Decubitus Ulcer — 2/1/01

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ David D. Right MD | D-17522 | 8/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Univ. of Md. Hospital D32N143 22 S. GREENE ST. BALT., MD. 21201

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | [signature] |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 27266

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Calvin | | Washington | August 6 2001 | 3:25 PM |
| 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of Death | | 4c. County of Death |
| University of Maryland Medical Center | | Baltimore | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-18-4121 | 1 X M 2 ☐ F | 78 Yrs. | | | 07/24/23 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1217 West Fayette Street | 21223 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW II | 1 ☐ Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th | | Maintenance | Private |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Martin Washington | Dorothy Washington |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy Washington | 3108 Gwynn Falls Pkwy., Baltimore, MD 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Garrison Forest | 08/15/01 | Reisterstown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Wesley Chavis, Jr., per DVR | Wesley Chavis, Jr., F.H. 2007 Eastern Avenue, Baltimore, MD 21231 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Cerebravascular Accident | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | 13886 | August 7, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward Mistler 22 South Greene Street Baltimore, Md. 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#7&20b per fh G798 082901 ss

# Certificate of Death

Reg. No. 2001 27267

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ernest Adams

2. Date of Death: Month 8 Day 27 Year 2001

3. Time of Death: 2:43 pM

4a. Facility Name (If not institution, give street and number): 1102 Druid Hill Ave. Apt. 1407

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-03-8891

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): ~~68~~ 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3 1 22

9. Birthplace (State or Foreign Country): Md.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1102 Druid Hill Ave. Apt. 1407

10f. Zip Code: 21217

10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipyard

16b. Kind of Business/Industry: Beth Steel

17. Father's Name (First, Middle, Last): Charles Randall

18. Mother's Name (First, Middle, Maiden Surname): Ella Shell

19a. Informant's Name/Relationship (Type, Print): Ernestine Means

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 N. Wolfe Street, Baltimore, Md. 21205

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Greenmount Cem~~. Greenmount Cemetery; Date: 8/29/01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Gladys Warren

22. Name and Address of Facility: Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease — Due to (or as a consequence of): — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension — Due to (or as a consequence of): — yrs

c. — Due to (or as a consequence of):

d. —

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Amatan M Naeem MD

29c. License number: D15503

29d. Date signed (Month, Day, Year): August 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amatan M NAEEM, 501 Dolphin street, Balto, MD 21217

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: ▶ D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

RR 371

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM #23a&b PER PHYG798 8/28/01 JH

Reg. No. 2001 27268

Alexander, Walter L.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Walter Lee Alexander, Sr.

2. Date of Death (Month, Day, Year): August 17, 2001

3. Time of Death: 5:00a M

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center Towson

4b. City, Town, or Location of Death:

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-09-5315

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/13/1917

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8226 Selwin Court

10f. Zip Code: 21237

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Stationary Engineer

16b. Kind of Business/Industry: VA Hospital

17. Father's Name (First, Middle, Last): Walter Spurrier Alexander

18. Mother's Name (First, Middle, Maiden Surname): Gladys Romain Cooper

19a. Informant's Name/Relationship (Type, Print): Mrs. Beverly H. Alexander/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8226 Selwin Court Balttimore, MD 21237

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grdns

Date: 08/20/2001

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Stephen Cole M0122

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ~~RENAL FAILURE~~ STROKE

Due to (or as a consequence of):

c. ~~STROKE~~

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: M.D

29c. License number: D50760

29d. Date signed (Month, Day, Year): 8/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES WENG 8415 Bellona Ln, Towson, MD 21204 Ste 216

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Lynn D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27269

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|---|
| Dorothy | | Boyce | August 27 2001 | 6:00 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| THE Johns Hopkins Hospital | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-22-8369 | 1☐M 2☒F | 74 Yrs. | | | May 8, 1927 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1201 Boyce Ave | 21204 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| C. Webster Abbott, Jr. | Dorothy Miller |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| C.Prevost Boyce, Jr. / husband | 1201 Boyce Ave., Baltimore, MD 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | August 29, 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Laura C Handsfield | CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CIRRHOSIS | 1 Month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☐Yes 2☒No |

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J.R. Murrow MD | RES-000 | August 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.R. Murrow, M.D. Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Jeanne G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27270

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Freny J. Boomla

2. Date of Death — Month: 08 Day: 27 Year: 2001

3. Time of Death: 6:45 AM

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Nursing & Rehab. Ctr

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 216-11-5521

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Nov 28 1916

9. Birthplace *(State or Foreign Country)*: India

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4639 Bettswood Drive

10f. Zip Code: 20832

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Indian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Dinshaw Gheyra

18. Mother's Name *(First, Middle, Maiden Surname)*: Gool Gheyra

19a. Informant's Name/Relationship *(Type, Print)*: Pearl Choki - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4639 Bettswood Drive Olney, MD 20832

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Washington Cr.

Date: 8/28/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Gloria M Dias

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CACER — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 28656

29d. Date signed *(Month, Day, Year)*: AUGUST 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVI TASSI MD 8609 SECOND AVE. #404B S. SPRING MD 20910

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27271

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles L. Bradenbaugh, Jr.

2. Date of Death: Month August Day 26, Year 2001

3. Time of Death: 6:00 A M

4a. Facility Name (If not institution, give street and number): Genesis-Long Green Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-12-6274

6. Sex: XX M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 12,1920

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1510 Kennewick Road

10f. Zip Code: 21218

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yr's

College (1-4or 5+): 2 yr's

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Agent

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Charles L. Bradenbaugh, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ethel Unkefer

19a. Informant's Name/Relationship (Type, Print): Charles L. Bradenbaugh, III-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 7 Box 7644 Bentz Rd. Springgrove, PA 17362

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service

Date: 8/28/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: ▶ Gary R. DiGiovanni

22. Name and Address of Facility: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic prostate Carcinoma — 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Rong Zhu (2HA.14) MD.

29c. License number: D0055059

29d. Date signed (Month, Day, Year): August 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 E. University Parkway, Baltimore, MD. 21218

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [illegible] P Coats

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RL

RC10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27272

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Bartuska

2. Data of Death: Month August, Day 23, Year 2001

3. Time of Death: 7:05 AM

4a. Facility Name (If not institution, give street and number): Mariner Health of Forest Hill

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 326-01-7793

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 30, 1906

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md

10b. County: Harford

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2206 Brookhaven Ct.

10f. Zip Code: 21047

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): factory worker

16b. Kind of Business/Industry: manufacturing

17. Father's Name (First, Middle, Last): Joseph Bartuska

18. Mother's Name (First, Middle, Maiden Surname): Antonia Bartuska

19a. Informant's Name/Relationship (Type, Print): Barbara Kraumann

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2206 Brookhaven Ct. Fallston, Md 21047

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel-Belair | Date: Aug 26 2001

20c. Location - City or Town, State: Forest Hill, Md

21. Signature of Funeral Service Licensee: Krista L Wells

22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Alzheimer's Type Dementia. | 10 years. |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D35012

29d. Date signed (Month, Day, Year): August 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27273

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| RALPH DENZIL BLAKE, SR. | AUGUST 25, 2001 | 7:30 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GENESIS ELDERCARE LOCH RAVEN | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 235-16-7668 | 1☒M 2☐F | 89 Yrs. | | | 11/13/1911 | W. VIRGINIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | RIDGELEIGH | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1838 WHITE OAK AVENUE | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5th GRADE | | CARPENTER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WALTER BLAKE | MINA ALLEN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DORIS J. LAM DAUGHTER | 1824 TRENLEIGH ROAD BALTIMORE, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | LITTLE KANAWHA MEM. GARDENS | 8/30/01 | FLATWOODS, W. VA |

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. COPD | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF Senile Dementia SVT Recurrent UTI,

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Martha Raymundo MD | 054518 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) martha raymundo 3007 E. Northern Parkway Baltimore MD 21214

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Denise D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

RR

RR 3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar: Amend Item 8,20a PER FH G798 08/28/01RR

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2001 27274

Physician /Medical Examiner | Funeral Director

To Be Completed by Funeral Director

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MICHAEL | | BLAIR | August 24, 2001 | 10:42 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE | BALTIMORE CITY |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-59-1869 | 1 [X] M 2 [ ] F | 1yr Yrs. | | | August 3, ~~01~~ 00 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Catonsville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 600 Plymouth Road | 21228 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | infant | infant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Steven Johns | Pauline Blair |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Pauline Blair- mother | 600 Plymouth Road, Catonsville, Md 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Loudon Park Cemetery | 08/28/01 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Bernard Palmarini | Witzke Funeral Home of CAtonsville, Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228 |

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Respiratory Distress Syndrome | 4 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Aspiration Pneumonia | 1 week |
| | c. Due to (or as a consequence of): Pterygoid Rhabdoid Sarcoma | 2 months |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 26f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D0053215 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WYNNE MORRISON, M.D.
600 N. WOLFE ST, BALTIMORE MD 21287

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Debra D Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27275

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy S. Beal

2. Date of Death (Month, Day, Year): August 24, 2001

3. Time of Death: 2017

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-09-2446

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 23, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3300 Benson Avenue

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): John C. Stolte

18. Mother's Name (First, Middle, Maiden Surname): Mary Louise Trostle

19a. Informant's Name/Relationship (Type, Print): Cathy Wolfson / niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8434 Dogwood Road Baltimore, MD 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Western Cemetery | Date: 08/28/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Edward A. Gregorchik

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. chronic obstructive pulmonary disease — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D47353

29d. Date signed (Month, Day, Year): August 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JON FALCK, MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: ▶ Geneva D Sparks

Beal, Dorothy

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No.: 2001 27276

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Louis John Bosica

2. Date of Death: Month August, Day 24, Year 2001

3. Time of Death: 1:40 A.M.

4a. Facility Name (If not institution, give street and number): 3731 Sylvan Drive

4b. City, Town, or Location of Death: Lochearn

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-03-5999

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 09/13/1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lochearn

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3731 Sylvan Drive

10f. Zip Code: 21207

10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Foreign Officer

16b. Kind of Business/Industry: MD National Guard

17. Father's Name (First, Middle, Last): John Bosica

18. Mother's Name (First, Middle, Maiden Surname): Julia Matricciani

19a. Informant's Name/Relationship (Type, Print): Denise Howes/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Three Willows CT Baltimore, MD 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cemetery

Date: 08/28/01

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Bernard Schwab

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. STROKE — 2WEEKS

Due to (or as a consequence of):
b. DIABETES MELLITUS — YEARS

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residance 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Gibbons, MD

29c. License number: D38296

29d. Date signed (Month, Day, Year): August 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: General D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27277

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): NEWMON BRADSHAW

2. Date of Death: Month August Day 23 Year 2001

3. Time of Death: 0610 AM

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center 3001 S. Hanover Street

4b. City, Town, or Location of Death: Baltimore, Maryland 21225

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213 09 3261

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 12, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1413 Church Street

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Auto Shop

17. Father's Name (First, Middle, Last): Bane Bradshaw

18. Mother's Name (First, Middle, Maiden Surname): Fannie Hoffer

19a. Informant's Name/Relationship (Type, Print): Rose Bradshaw / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1413 Church Street Baltimore, Maryland 21225

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 8/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Sharron Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ACUTE RESPIRATORY FAILIURE | 6 HOURS. |
| Due to (or as a consequence of): b. | RIGHT MIDDLE LOBE PNEMONIA AND EFFUSION | 2WEEKS |
| Due to (or as a consequence of): c. | CONGESTIVE CARDIAC FAILIURE | 3 YEARS |
| Due to (or as a consequence of): d. | HYPERTENSION | 5 YEARS. |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER,

GASTRIC CANCER.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [/] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [/] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shadaba INTERNAL PGY-1 MEDICINE

29c. License number: RE5000

29d. Date signed (Month, Day, Year): AUGUST 24 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHADABA ASAD 3001 SOUTH HANOVER ST. BALTIMORE 21225 MD.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Bruce B Sparks

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27278

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Estelle Maria Beyer

2. Date of Death: Month August, Day 26, Year 2001

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): Mariner Health of Forest Hill

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 086-38-1826

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): March 14, 1910

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 109 Forest Valley Drive

10f. Zip Code: 21050

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary

16b. Kind of Business/Industry: Law Office

17. Father's Name (First, Middle, Last): Casimir Schuster

18. Mother's Name (First, Middle, Maiden Surname): Louisa Hallameyer

19a. Informant's Name/Relationship (Type, Print): Janice Diana/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Belmont Court Bel Air MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): The Evergreens Cemetery

Date: 8/29/01

20c. Location - City or Town, State: Brooklyn New York

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. dementia — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D20136

29d. Date signed (Month, Day, Year): 8-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Duncan 615 W. MacPhail BelAir, MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Gordon G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27279

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Louis Becker SR | 8-26-01 | 8 10pm M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-09-5247 | 1☒M 2☐F | 83 Yrs. | | | 8-9-18 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3100 Westfield Avenue | 21214 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Electrician | Union |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| August Becker | Margaret Osman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gene Becker/Son | 3100 Westfield Avenue Baltimore, Maryland 21214 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Providence Methodist | 8/29/01 | Gamber, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pulmonary edema | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Stroke - bilateral | 3 weeks |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
asbestosis
(L) atrial / (L) ventricular thrombus

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Lori Jordan MD | RES-000 | 8/26/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lori JORDAN, JHH Pathology 509, 600 N. Wolfe St Balt. MD 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#5 per fh G798 083001 SS

# Certificate of Death

Reg. No. 2001 27280

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Raymond F. Bateman

2. Date of Death: Month Aug Day 26 Year 2001

3. Time of Death: 7:05 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 216-32-5267 ~~216-32-5260~~

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 27 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 810 Danza Road

10f. Zip Code: 21144

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): State Trooper

16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): William R. Bateman

18. Mother's Name (First, Middle, Maiden Surname): Mary Wagner

19a. Informant's Name/Relationship (Type, Print): Ronald S. Bateman (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 712 Crucible Court, Millersville, MD. 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.

Date: Aug. 29 2001

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Pancreatic Cancer — 1 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ House Officer

29c. License number: D53642

29d. Date signed (Month, Day, Year): Aug 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 301 Hospital Drive Glen Burnie MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature ▶ [illegible] Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Eva Bush

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27281

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Eva Martin Bush | August 26, 2001 | 10:30 P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Edenwald Retirement Center | Towson | Baltimore County |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-48-3361 | 1☐M 2☒F | 90 Yrs. | | | November 26, 1910 | Hampstead, Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore County | Towson | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 800 Southerly Road | 21286 | United States of America |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 2 | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Wesley Martin | Minnie Wisner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph Edgar Bush, Jr., M.D. (Son) | 4 Junco Court Cockeysville, Maryland 21030-2613 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hampstead Cemetery | 8/29/2001 | Hampstead, Maryland |

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive heart failure | 2yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): a flow obstructive disease | 10yrs |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| physician | D29769 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcelino D. Alcoverre MD 516 N. Rolling Rd Balto md 21228

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | D. Sparks |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27282

AMENDED ITEM#25 per ME G799 091901 SS

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Betty | Jean | Cassidy | August 20, 2001 | 11:00am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Montgomery General Hospital | Olney | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 502-46-3331 | 1☐ M 2☒ F | 56 Yrs. | | | Oct. 2, 1944 | Gregory, SD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Springs | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| #5 Narrows Court | 20906 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grede completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | Administrative Assistant | Church Office |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Arthur M. Hoffmann | Anna L. Gimbel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) |
|---|---|
| Martin S. Cassidy Husband | #5 Narrows Court, Silver Springs MD 20906 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cematary, cremetory or other piece) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | Riverside Cemetery | August 28 2001 | Huron, SD |

21. Signature of Funeral Service Licensee: Victor P. Doda

22. Name and Address of Facility: Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md 21230

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition resulting in death) | a. Metastatic Breast Cancer | Months |
| | Dua to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that tritiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Dua to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yas 2☒ No | 1☐ Yes 2☐ No |

| 25. Was casa rafarrad to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yas 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) |

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| MD | 033686 | August 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ken Miller M.D. 18111 Prince Philip Drive #327, Olney Md 20832

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrer's Signature |
|---|---|
| AUG 28 2001 | Geneva D. Sparks |

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

#25

8

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**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS#19a,b per ME G799 091301 SS

# Certificate of Death

Reg. No. 2001 27283

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie Cole

2. Date of Death (Month, Day, Year): August 26 2001

3. Time of Death: 4:15pm

4a. Facility Name (If not institution, give street and number): Ivy Hall Nursing Center

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 121-28-3627

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 101 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 31 1900

9. Birthplace (State or Foreign Country): NewYork

Usual Residence of Decedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 44 Left Wing Drive

10f. Zip Code: 21220

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Edgar Butler

18. Mother's Name (First, Middle, Maiden Surname): Ella VanValkenburg

19a. Informant's Name/Relationship (Type, Print): Ellida Lancaster/daughter ~~-in law-~~

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6409 Golden ~~Rind~~ Ring Road Baltimore MD 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): HollyHillCemetery | Dete: 8/30/01

20c. Location - City or Town, State: Baltimore MD

21. Signeture of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 MAce Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not entar the mode of dying, such as cerdiac or raspiratory arrast, shock, or haart faitura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequance of):

b. MALNUTRITION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner stated.

29b. Signature and title of certifier: Stanislav K Tsilka MD

29c. License number: D27158

29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stanislav K Tsilka 2 Market Place Balt. MD 21222

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

RR

RR3

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27284

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN PETER COLEMAN JR.

2. Date of Death Month: August Day: 26 Year: 2001

3. Time of Death: 11:35 P M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-09-0049

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 542 South 48th Street

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipe Fitter

16b. Kind of Business/Industry: Maryland Drydock

17. Father's Name (First, Middle, Last): John P. Coleman Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret Hofheinz

19a. Informant's Name/Relationship (Type, Print): Charles Coleman /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 542 South 48th Street Baltimore MD 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): OAk Lawn Cemetery Date: 8/29/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

**To Be Completed by Funeral Director**

Coleman, John

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cachexia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Liver Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency: 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Cardiomyopathy
- Chronic renal failure
- Atherosclerotic Disease

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. 2 [ ] Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D38882

29d. Date signed (Month, Day, Year): 08/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid Al-Talib, 9000 Franklin Squre Dr. Baltmor, MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Donna D Sparks

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 6

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27285

CRAWFORD, WOODROW

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WOODROW G. CRAWFORD
2. Date of Death — Month: 08 Day: 25 Year: 01
3. Time of Death: 2350
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 231 16 7181
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 25, 1923
9. Birthplace (State or Foreign Country): West Virginia

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 313 Hospital Drive
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1947 - 1950
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): W. G. Crawford
18. Mother's Name (First, Middle, Maiden Surname): Serrah Broscus

19a. Informant's Name/Relationship (Type, Print): Mildred Honeycutt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 Aquahart Road Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Md. State Veteran Cem.
Date: 8/28/01
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Shannon Liggett
22. Name end Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D45149
29d. Date signed (Month, Day, Year): AUGUST 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARTO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27286

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Dolores | Cornias | August 24th 2001 | 11:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Hospital | Baltimore City | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217 24 2291 | 1 M 2 F | 72 Yrs. | | | 1-14-1929 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1249 Deanwood Road | 21234 | U. S. A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Bukowski | Susanna Lazarewicz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Gus J. Cornias (Son) | 1249 Deanwood Road, Baltimore, Maryland 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Entombment Moreland Mem. Maus. | 8-28-01 | Parkville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Wallace S. Brooks, Jr. | Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chylothorax

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN CHF

HTN dissecting Thoracic Aortic dissection

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 No 3 Probably 4 Unknown | 1 Yes 2 No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D0056632 | August 24th 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEE GARDIE JEAN 10512 CASCADE RUN COURT OWINGS ,MD 21117

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Brenda D Sparks |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27287

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Ronald Melvin Cox, Sr.

2. Date of Death Month Aug Day 27, Year 2001

3. Time of Death: 10:10 am

4a Facility Neme *(If not institution, give street end number)*: Future Care Old Court

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 442-22-4476

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Sept 26, 1926

9. Birthplace *(State or Foreign Country)*: Oklahoma

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 421 Highmeadow Road

10f. Zip Code: 21136

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Edeution *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Ft Lincoln Cemetery

17. Father's Neme *(First, Middle, Last)*: Odis Cox

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Fortner

19e. Informent's Neme/Reletionship *(Type, Print)*: Diane Karr Daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 421 Highmeadow Road Reisterstown, MD 21136

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Carroll Cremation Ser

Date: 8/28/01

20c. Location - City or Town, Stete: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ Mike Dubois

22. Neme end Address of Fecility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Hyponatzemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. SIADH

Due to (or es a consequence of):

c. Pneumonia

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Dementea

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ T. Kawaja

29c. License number: D25112

29d. Dete signed *(Month, Day, Year)*: 8/27/2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): TAHOORA KAWAJA 20 Crossroads Dr Suite 101 Owings Mills MD 21117.

**State Registrar**

31. Dete filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signeture: ▶ Jenna D. Sparks

DHMH 16 Rev 6/95

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

RONALD COX

K

1

01-4777-003
OLLIE DUNCAN
ASP

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27288

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ollie L. Duncan
2. Date of Death (Month, Day, Year): AUGUST 20 2001
3. Time of Death: 0410
4a. Facility Name (If not institution, give street and number): MARINA HEALTH NURSING HOME
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 260-14-9965
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04 15 21
9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 [ ] Yes 2 [X] No XX
10e. Street and Number: 10004 Enford Ct.
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade | College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Foreman
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Jeffrey Duncan
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Nadine Anderson-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10004 Enford Ct., Lanham, Md 20706

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetery
Date: 8/25/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Glynn D. Keke
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disease or condition resulting in death): a. Cardiac Arrythmia
Due to (or as a consequence of): b. Hypertensive Cardiovascular Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or es e consequence of): c.
Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. Tins
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUGUST 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

RR
RR 5

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #29d PER PHY G799 8/06/01 JH

# Certificate of Death

Reg. No. 2001 27289

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARGARET ELIZABETH DAHLE | AUGUST 26, 2001 | 10:30A |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-01-0233 | 1☐M 2☒F | 80 Yrs. | | | NOVEMBER 7, 1920 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | N/A | BALTIMORE CITY | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5101 EDGAR TERRACE | 21214 | UNITED STATES OF AMERICA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 YEARS | SCHOOL TEACHER | BALTIMORE CITY SCHOOLS |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES WICKER | JENNIE AUGUST |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALLEN W. DAHLE / SON | 4400 SOUTH SHORE DRIVE / PRINCE FREDERICK, MD. 20678 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | PARKWOOD CEMETERY | AUGUST 29, 2001 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Donald R. Watson, Jr. #M00612 | ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. LUNG CANCER ADVANCED METASTASES | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. HYPOXIA | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D 53593 | AUGUST 27, 2001 |

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
ASHRAF S. MOSTAFA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ George B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 6,7 PER FH G798 08/28/01 RR

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27290

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Samuel Esters

2. Date of Death: Month Aug, Day 20, Year 2001

3. Time of Death: 2025

4a. Facility Name (If not institution, give street end number): Anne Arundel Gen Hosp

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: AA

**Funeral Director**

5. Social Security Number: 214-40-8705

6. Sex: 1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sep 23, ~~2001~~ 1941

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: 513 Horn Point Drive

10f. Zip Code: 21403

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Photographer

16b. Kind of Business/Industry: Photgraphy

17. Father's Name (First, Middle, Last): Samuel Esters

18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Quickly

19a. Informant's Name/Relationship (Type, Print): Mr. William Esters-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9710 Mendoza Rd., Randallstown, MD 21233

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Annapolis Mem. Gardens

Date: Aug 30 2001

20c. Location - City or Town, State: Annapolis, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GASTROENTERITIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiac Hypertrophy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy ME

29c. License number: D06054

29d. Date signed (Month, Day, Year): 8/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 645 America 21035

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Donna P Sparks

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS 14,15&16b PER FH G799 9/26/01 JH

# Certificate of Death

Reg. No. 2001 27291

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie Lovett Fraser

2. Date of Death: Month August Day 22, Year 2001

3. Time of Death: 6:08am

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 055-16-1683

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-08-08

9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No XX

10e. Street and Number: 9 C Hamill Road

10f. Zip Code: 21210

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married XX☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: MULTI-RACIAL ~~Black~~

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+): ~~NA~~ 5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: BALTIMORE PUBLIC ~~Comapny~~ SCHOOL SYSTEM

17. Father's Name (First, Middle, Last): Robert Lovett

18. Mother's Name (First, Middle, Maiden Surname): Augusta Braboy

19a. Informant's Name/Relationship (Type, Print): Dolores Fraser Cave

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7432 Ascot Court University Park, FL. 34201

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Cem.

Date: 08-29-01

20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: Dale March

22. Name and Address of Facility: WM.C.March FH, West 4300 Wabash Avenue Baltimore, Maryland 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Progressive Dementia — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. R. Left GBMC 6701 N. Charles St. Balto, Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Medical Certification: To Be Completed by Physician/Medical Examiner**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8/22/01 6:08A

Maria Fraser RR

RR 12

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27292

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| THOMAS LAWRENCE FEEHELY | AUGUST 25, 2001 | 4:25 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST. JOSEPH'S HOSPITAL | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-46-3922 | 1 [X] M 2 [ ] F | 54 Yrs. | | | Jan 25, 1947 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | N/A | BALTIMORE | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3506 FAIT AVENUE | 21224 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: XX | 1 [ ] Yes 2 [X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | CARPENTER | JOHNS HOPKINS HOSP. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THOMAS FEEHELY | ANNA THOMAS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DONNA THOMAS/ SISTER | 6909A MT. VISTA ROAD, KINGSVILLE, MD. 21087 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | SACRED HEART OF JESUS | 8/29/01 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [✓] No | 1 [ ] Yes 2 [✓] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [✓] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [✓] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Charles F. O'Donnell MD | 09383 | AUGUST 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD, Hamlet Hill Rd Apt 408-Baltimore MD 21210

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27293

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Beyer Grose

2. Date of Death: Month AUGUST Day 25 Year 2001

3. Time of Death: 10:46 AM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-14-0175

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 5, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 700 W. 40th Street Keswick Multi-Care

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker

18b. Kind of Business/Industry: Marine Supply

17. Father's Name (First, Middle, Last): Clarles Lawrence Beyer

18. Mother's Name (First, Middle, Maiden Surname): Myrtle Gertrude Shipley

19a. Informant's Name/Relationship (Type, Print): Janet Westervelt Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 Green Meadow Dr. Timonium, MD 21093

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem. Date: 8/28/01

20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA — 2 DAYS

Due to (or as a consequence of):

b. HYPOXIA — 2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END-STAGE RENAL DISEASE, DIABETES MELLITUS, HYPERCHOLESTEROLEMIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elaine Kling MEDICAL DOCTOR

29c. Licanse number: AT2438946

29d. Date signed (Month, Day, Year): AUGUST 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELAINE KLING 201 E. University Parkway Union Memorial Hospital BALTO, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Geneva D Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27294

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Roland Green | August 27, 2001 | 9:10 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2009 Englewood Road | Woodlawn | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-22-4046 | 1☒M 2☐F | 73 Yrs. | | | June 5, 1928 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Woodlawn | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2009 Englewood Avenue | 21207 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Brick Layer | Central Maryland Masonary |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Green | Ethel (High) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia S. Green Wife | 2009 Englewood Avenue; Woodlawn, Maryland 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lorraine Park | 8/30/01 | Woodlawn, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Joseph J. Kellner | Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Lymphoma | 6 Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| If FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Paul R. Gormley MD | D18587 | AUG 28, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL GORMLEY 3350 Wilkens Ave, Suite 100 Balto MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Jeanne M Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27295

GILCHREST, FREDA

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Freda M. Gilchrest | AUGUST 27, 2001 | 5:35 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| FRANKLIN SQUARE HOSPITAL | ROSEDALE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 016-18-4559 | 1☐M 2☒F | 90 Yrs. | | | April 14,1911 | Baltimore,MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MA | Middlesex | Townsend | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 66 Dudley Rd. | 01469 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Pueno Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Collator | Printing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| William Marks | Ruth Rowden |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara A. Stevens Daughter | 11408 Smiloff Rd. White Marsh,MD 21162 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify) | Hillside Cemetery | Sept. 01 2001 | Townsend, MA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Victor R. Doda | Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 21230 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Immediate Cause (Finel disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 24 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. GASTROINTESTINAL BLEEDING — 7 DAYS

Due to (or es a consequence of):

c. _____

Due to (or as e consequence of):

d. _____

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | 23d. Dete of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? 1☐Yes 2☒No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No |
|---|---|

| 25. Was case referred to medical examiner? 1☐Yes 2☒No | 26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |
|---|---|

| 27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M Chatham | D20907 | AUGUST 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIE CHATHAM, M.D. 9000 FRANKLIN SQUARE DRIVE BALTIMORE, M.D. 21237

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27296

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: WILMA MARIE GEISLER

2. Date of Death *(Month, Day, Year)*: Aug 26 2001

3. Time of Death: 1:05 PM

4a. Facility Name *(If not institution, give street and number)*: LEVINDALE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-12-4553

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/26/1919

9. Birthplace *(State or Foreign Country)*: GERMANY

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No X

10e. Street and Number: 1638 YAKONA ROAD

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: HENRY HEINE

18. Mother's Name *(First, Middle, Maiden Surname)*: THERESA ARBUS

19a. Informant's Name/Relationship *(Type, Print)*: MICHAEL GEISLER SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2829 ERIE AVE. BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LORRAINE PARK CEMETERY

Date: 8/29/01

20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] MD

29c. License number: D23767

29d. Date signed *(Month, Day, Year)*: August 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Debra S Wertheimer MD 2434 W. Belvedere Ave. Balto, MD 21215

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature ▶ [signature] D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

GEISLER, WILMA RR 5 RR

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27297

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Ralph D. Good | August 26, 2001 | 12:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1138 McAdoo Avenue | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-38-0636 | 1 [X] M 2 [ ] F | 60 Yrs. | | | JANUARY 14, 1941 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1138 McAdoo Avenue | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: X | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Die Maker | Dixie Premium packaging |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Martin E. Good | Virginia Funk |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judy Good- wife | 1138 McAdoo Avenue, Baltimore, Md.21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Balto./Wash. Crematory | 08/29/01 | Laurel, Md. |

21. Signature of Funeral Service Licensee: ▶ Kyle Schlanger MD201

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc, 1630 Edmondson Avenue, Catonsville, Md. 21228

**Physician /Medical Examiner**

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC PROSTATE CANCER | 2 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION, DIABETES MELLITUS

PULMONARY EMBOLUS

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature], MD | D38296 | August 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27298

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Otto M. Gross | August 26, 2001 | 2:20 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-9561 | 1 ☒ M 2 ☐ F | 85 Yrs. | | | Feb 27, 1916 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Lutherville | 1 ☐ Yes 2 ☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1610 York Rd. | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Self Employed | Barber |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Mathias Gross | Hilda Peschke |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Carol Hilgartner/ Daughter | 1610 York Rd. Lutherville, Md. 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Dulaney Valley Mem. | 8-29-01 | Timonium, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b. | Chronic Obstructive Pulmonary Disease | Years |
| Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) — 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D37362 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anthony Serafis MD 1105 York Rd 32c Lutherville Md 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ D. Sparks |

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27299

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PETER GOODWIN

2. Date of Death (Month, Day, Year): AUGUST 19 2001

3. Time of Death: 10:48 A

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 217-50-5573

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yeer)*: DEC 24 1947

9. Birthplace *(Stete or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 232 North Potomac Street

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): Unknown / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Pet Industry

17. Fathar's Name *(First, Middle, Last)*: Lawrence Goodwin

18. Mother's Name *(First, Middle, Maiden Surneme)*: Regina Shine Goodwin

19a. Informant's Name/Relationship *(Type, Print)*: Pamela Goodwin (Wife)

19b. Melling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 232 North Potomac St. Hagerstown, MD 21740

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: State Anatomy Board

Date: 8-20-01

20c. Location - City or Town, Stata: 655 W. Baltimore St Baltimore, MD 21201

21. Signature of Funeral Service Licensee: M00173

22. Name and Address of Facility: I.I.A.M. 1232 Midvalley Drive Jessup, Pennsylvania 18434

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the daath. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final diseese or condition resulting in death) a. | VENTRICULAR FIBRILLATION | 20 MINS |
| Due to (or es e consequence of): b. | MYOCARDIAL INFARCTION | 45 MINS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last — Due to (or as a consequence of): c. | CORONARY ARTERY DISEASE | 10 YEARS |
| Dua to (or as a consequence of): d. | | |

Part II. **Other elgnificant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

TRACHEAL STENOSIS

HYPOXIC ENCEPHALOPATHY

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings svailable prior to completion of causa of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [✓] No

26. Piace of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piace of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: BAyi, MD

29c. Licansa number: P13451

29d. Data signed *(Month, Dey, Year)*: AUG 19TH, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERTHA AYI, MD 5601 LOCH RAVEN BLVD. BALT MD 21239 GOOD SAMARITAN HOSPITAL

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 27300

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: **Myrtle Lee Garland**

2. Date of Death Month Day Year: Aug 18, 2001

3. Time of Death: 9:45 p.m

4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice, Inc.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 212-18-2058

6. Sex: 1☐ M X 2☐ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 17, 1910

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes X 2☐ No

10e. Street and Number: 3339 North Chatham Rd.

10f. Zip Code: 21042

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3X Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 3X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes X☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk. / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service Manager

16b. Kind of Business/Industry: St. Government

17. Father's Name *(First, Middle, Last)*: Frank Campbell

18. Mother's Name *(First, Middle, Maiden Surname)*: Chloe Simpson

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Denise King

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1108 Underwood Rd. Sykesville, Maryland 21784

20a. Method of Disposition: X Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial Gardens

Date: 08/22/01

20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] Mo III 3

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Transitional Cell Cancer of Bladder — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, Coronary Artery Disease, ASCVD

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other *(Specify)* INPATIENT HOSPICE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.

29c. License number: D41476

29d. Date signed *(Month, Day, Year)*: 08/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND W. WILSON M.D. 6565 N. Charles St. #416, Baltimore, MD. 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: ▶ [signature] D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Myrtle Garland 945 P 8/18/01

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27301

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Thomann George | 08 / 22 / 01 | 1042 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University Maryland Medical Center | Baltimore | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 532-42-3126 | 1 X M 2 ☐ F | 79 Yrs. | | | Oct 4, 1921 | Switzerland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Clarksville | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6384 Guilford Rd. | 21029 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - American Indian, Black, White, atc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yas 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highast grade completed) | | 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Engineer | Engineering |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Nama (First, Middla, Maiden Surname) |
|---|---|
| Georges Thomann | Marie Louise Eicher |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) |
|---|---|
| Ms. Shirley F. Thomann | 6384 Guilford Rd. Clarksville, Maryland 21029 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Nama of cematary, crametory or othar place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) | All County Cremation Services, Inc. | 08/25/01 | Sykesville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| Timothy S. Slack M01113 | Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach line.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. esophageal cancer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. cerebral vascular accident | |
| | Due to (or as e consequence of): c. | |
| | Dua to (or as a consequance of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcoma of pregnancy 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at tima of daath 5 ☐ Othar (specify) 9 ☐ Unknown | 23d. Date of dalivary Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

| 23a. Did tobacco usa contributa to tha causa of daath? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 X Unknown | |
|---|---|
| 24a. Was an autopsy performed? 1 ☐ Yas 2 X No | 24b. Wara autopsy findings availabla prior to completion of cause of daath? 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? 1 ☐ Yes 2 X No | 28. Place of Daath (Check only ona) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined | 28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) | | | 28f. Location (Street and Numbar or Rural Routa Number, City or Town, State) |

29a. Certifier (Check only one) 1 X **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to the causa(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| | A4417643577X6 | 08/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. N. Tokoo 22 S. Greene St Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| AUG 28 2001 | D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27302

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARY DENNIS GOULD | AUGUST 27, 2001 | 4:50 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| BLAKEHURST RETIREMENT COMM. | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-46-0974 | 1 ☐ M XX F | 95 Yrs. | | | 03-31-1906 | MARYLAND |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | BALTIMORE | TOWSON | 1 ☐ Yes XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1055 WEST JOPPA ROAD | 21204 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 1 ☐ Yes XX No If Yes, Give Year or Dates: | 1 ☐ Yes XX No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 YEARS | | HOUSEWIFE | OWN HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| JOHN McPHERSON DENNIS | MARY CARR |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRANCES G. FOX (DAUGHTER) | 941 W.PADONIA RD.,COCKEYSVILLE,MD.,21030 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | WOODLAWN CEMETERY | 08-29-2001 | WOODLAWN, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ R. G. Keith | HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC ENDOMETRIAL CANCER | 6 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes XX No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes XX No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes XX No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Willie D. McConnell M.D. | D 42129 | AUGUST 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM D. McCONNELL, M.D.,500 WEST UNIVERSITY PKWY,BALTO.,MD.21210

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Penny B. Sparks |

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27303

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beulah Beatrice Harne

2. Date of Death Month Day Year: August 27 2001

3. Time of Death: 3:45 PM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-26-0132

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 10, 1919

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 414 Lorraine Ave

10f. Zip Code: 21221

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barmaid

16b. Kind of Business/Industry: 313 (Bar)

17. Father's Name (First, Middle, Last): Bill Grymes

18. Mother's Name (First, Middle, Maiden Surname): Ora Brooks

19a. Informant's Name/Relationship (Type, Print): Peggy Mae McGreevy / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 464 Mirabile Lane., Baltimore, MD 21224

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: Aug. 29, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Towson, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Malignant Pleural Effusion

Due to (or as a consequence of):

c. Endometrial Cancer

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rubinson, MD

29c. License number: D56127

29d. Date signed (Month, Day, Year): August 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Lewis Rubinson 9000 Franklin Square Dr. Baltimore Md 21237

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Beulah Harne

RR

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27304

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| ERNEST | HIGGINBOTHAM | | August 20 2001 | 15 10 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| THE Johns Hopkins Hospital | Baltimore City | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 233-64-8427 | 1☒M 2☐F | 60 Yrs. | | | June 27, 1941 | unk |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| DC | | Washington | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizan of What Country? |
|---|---|---|
| 1301 Saratoga Avenue #3 | 20018 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| unk 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No unk If Yes, Give Yaar or Dates: | 1☐Yes 2☒No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Nama (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumama) |
|---|---|
| unk | unk |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) |
|---|---|
| Johns Hopkins Hospital | 600 Wolfe Street Baltimore, MD 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in store | | | |

| 21. Signature of Funeral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| ▶ Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximata Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death)

a. ACUTE ISCHEMIC STROKE — 4 DAYS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE — MONTHS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant condftions** contributing lo death but not rasulting in the underlying cause given in Part I.

HUMAN IMMUNODEFICIENCY VIRUS

| 23e. Did tobacco use contribute to tha cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to compiation of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) | 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and dua to tha causa(s) and mannar as stated.

2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and manner stated.

| 29b. Signatura and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Jeffrey A. Rumbaugh MD | RES-000 | AUGUST 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY A. RUMBAUGH JOHNS HOPKINS HOSPITAL 600 WOLFE STREET BALTIMORE MARYLAND 21287

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signatura |
|---|---|
| AUG 28 2001 | ▶ Bernice D Sparks |

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27305

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| WILLIAM HARMAN | August 23, 2001 | 4:50 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northwest Hospital Center | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-10-0134 | 1☒M 2☐F | 91 Yrs. | | | Nov. 25, 1909 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Owings Mills | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 17 South Ritters Lane | 21117 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11th Grade | -0- | Correctional Officer | Maryland Penitentiary |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Karl Wilton Harman | Sarah Ann Horn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Jennie Harman - Wife | 17 South Ritters Lane; Owings Mills, Maryland 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Lake View Mem. Park | 8/27/2001 | Sykesville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00869 | Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pleural Effusion | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yaar) |
|---|---|---|
| MD | D44505 | August 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. J. IMPERIAL Jr. MD NWHC

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Jennie D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item 6 PER FH G799 09/04/01 **Certificate of Death** RR Reg. No. 2001 27306

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ophelia Henderson
2. Data of Death — Month: August; Day: 24; Yaar: 2001
3. Tima of Death: 1240 pm
4a. Facility Nama *(If not institution, giva streat and number)*: John Hopkins Bayview Geriatic
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-30-1492
6. Sex: 1 ☒ M 2 ☒ F
7. Aga *(In yrs. last birthday)*: 99 Yrs.
If Undar 1 Yaar — Months: ; Days: ; If Undar 24 Hrs. — Hours: ; Min.:
8. Data of Birth *(Month, Day, Yaar)*: 7 4 02
9. Birthplaca *(Stata or Foreign Country)*: Va.

Usual Rasidanca of Decadant

10a. Stata: Md.
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 ☒ Yas 2 ☐ No
10e. Street and Number: 932 N. Durham Street
10f. Zip Coda: 21205
10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Marriad 3 ☒ Widowed 4 ☐ Divorcad
12. Was Dacedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedant's Education *(Spacify only highast grada completed)*: Elamantary/Secondary (0-12): NA; Collega (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Supervisor- Housekeeping
16b. Kind of Businass/Industry: Johns Hopkins Hosp.

17. Fathar's Nama *(First, Middla, Last)*: William Booker
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Nick Lee

19a. Informant's Name/Ralationship *(Type, Print)*: Viola Johnson
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1225 Genito Rd., Burkeville, Va. 23922

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: High Rock Bapt. Ch Cem
Data: 8/31/01
20c. Location - City or Town, Stata: Rice, Va.

21. Signatura of Funaral Sarvica Licansee: ▶ Gladys Wood
22. Nama and Addrass of Facility: Baltimore, Md. 21202 — March F.H. East 1101 E. North Ave.

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)
a. Stroke — 3 years
Dua to (or as a consaquanca of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last
b.
Dua to (or as a consaquance of):
c.
Dua to (or as a consaquance of):
d.

RR

Part II. Othar significant conditions contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Wara autopsy findings availabla prior to compliation of causa of death? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☒ No
26. Placa of Daath *(Check only ona)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Othar: 4 ☒ Nursing Homa 5 ☐ Rasidance 8 ☐ Othar *(Specify)*
27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarminad
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Cartifiar *(Check only one)*: 1 ☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.
29b. Signatura and fitla of certifiar: ▶ Thomas Finucane MD
29c. Licansa number: D 24334
29d. Data signed *(Month, Day, Yaar)*: August 24, 2001
30. Nama and addrass of parson who compliatad causa of daath (Itam 23a) (Typa, Print): THOMAS FINUCANE MD — Johns Hopkins Geriatrics Center

RR 6

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: AUG 28 2001
32. Registrar's Signatura: Penny B Sparks

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

RJD
DAPHNE HAMILTON
01-4810-510

UNPENDED 091001:ITEMS#23a,ptII,27 per ME G799 SS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27307

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DAPHNE MICHELLE HAMILTON

2. Date of Death (Month, Day, Year): AUGUST 22, 2001

3. Time of Death: 0049 A.M.

4a. Facility Name (If not institution, give street and number): 1339 MOSHER ST.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-84-4916

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 7 1966

9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1020 N. CALHOUN STREET

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER

16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): HENRY MAC HAMILTON

18. Mother's Name (First, Middle, Maiden Surname): GLORIA HAMILTON BURTON

19a. Informant's Name/Relationship (Type, Print): Gloria H. Burton/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5255 St. Charles Avenue, Balto., Md 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | Date: 8-29-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTROPHIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE BRONCHOPNEUMONIA, FATTY LIVER, CHRONIC PANCREATITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) (SCENE)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): AUGUST 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27308

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bernard G. Hause
2. Date of Death (Month, Day, Year): August 23, 2001
3. Time of Death: 9:00pm M
4a. Facility Name (If not institution, give street and number): 15100 Inter Lachen Drive
4b. City, Town, or Location of Death: Silver Springs
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 198-26-1441
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 22, 1933
9. Birthplace (State or Foreign Country): Tarentum, PA

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 15100 Interlachen Drive
10f. Zip Code: 20906
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labor Economist
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): George Hause
18. Mother's Name (First, Middle, Maiden Surname): Leona Settles

19a. Informant's Name/Relationship (Type, Print): Jane Hause Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15100 Interlachen Dr. Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart-St. Peter Cem. Date: August 27, 2001
20c. Location - City or Town, State: Tarentum, PA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 21230

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 1994

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Diabetis Meletis — 1994
Due to (or as a consequence of):
c. High Blood Presure — 1994
Due to (or as a consequence of):
d. ASCVD — 1994

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] GB Patrick III MD
29c. License number: D17729
29d. Date signed (Month, Day, Year): August 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George B. Patrick III, MD 9221 Colesville Rd. Silver Spring MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27309

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LOUIS A. HENDERSON SR.

2. Date of Death (Month, Day, Year): August 26, 2001

3. Time of Death: 7:25AM.

4a. Facility Name *(If not institution, give street and number)*: VAMHCS - Fort Howard Division

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-24-8038

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9/11/29

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 2403 TERRA FIRMA RD.

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: FACTORY

17. Father's Name *(First, Middle, Last)*: JOHN W. HENDERSON

18. Mother's Name *(First, Middle, Maiden Surname)*: CALLIE GREEN

19a. Informant's Name/Relationship *(Type, Print)*: CLARA D. HENDERSON (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2403 TERRA FRIMA RD. BALTIMORE, MD 21225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet. Cem.

Date: 8/31/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME P.A. 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] MD

29c. License number: D57239

29d. Date signed *(Month, Day, Year)*: August 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Suresh Shandelya - 9600 North Point Road, Fort Howard, MD 21052

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature ▶ [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Louis Henderson

B

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27310

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Carolyn DallaValle Huber | August 24, 2001 | 1630 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 145-26-9057 | 1☐M 2☒F | 64 Yrs. | | | July 02, 1937 | Wash..D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2608 Shanandale Drive | 20904-1629 | USA |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) | 14. Rece - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Sumame) |
|---|---|
| Joseph Marius DallaValle | Lucy Carolyn Small |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Alfred G. Huber- husband | 2608 Shanandale Drive, Silver Spring, Md.20904-1629 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Steta |
|---|---|---|---|
| 1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify) | Balto/Wash. Crematory | 08/30/01 | Laurel, Md. |

21. Signature of Funeral Service Licensee: Bernard Dallaville

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Md. 21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respirarty arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervet Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infraction
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atherosclerotic Coronary Artery Disease
Due to (or as e consequence of):
c. Diabetic Mellitus
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnency 4☐Pregnant et tima of deeth 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner es steted. 2☐Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to tha ceusa(s) end menner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D41624 | 08/25/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patrick Murphy, Holy Cross Hospital Silver Spring, Md.

**State Registrar**

| 31. Dete filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Sonya G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27311

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Michael Hare

2. Date of Death: Month: August Dey: 24 Year: 2001

3. Time of Death: 7:05 AM

4a. Facility Name (If not institution, give street and number): VA Medical Center, Fort Howard Md 21052

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-38-9989

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 08-06-1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Anne Arundel | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5225 6th Street | 10f. Zip Code: 21225 | 10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cabinet Maker

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Walter Hare

18. Mother's Name (First, Middle, Maiden Surname): Florence Marie Zyski

19a. Informant's Name/Relationship (Type, Print): Annie Hare (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5225 6th Street Baltimore, MD 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veteran Cemetery | Date: 8/27/01 | 20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Shannon Leggett

22. Name and Address of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225

William M Hare
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic oro-pharyngeal cancer — 15 months

Due to (or es a consequence of):

Sequentially list conditions, If any, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Marcos Galicia M.D.

29c. License number: D0015698

29d. Date signed (Month, Day, Year): Aug. 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARCOS GALICIA, M.D. 9600 North Point Road, Fort Howard Md 21052

**State Registrar**

31. Date filed (Month, Dey, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27312

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Vera Marie Heeter | August 25 2001 | 01:05A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST AGNES HEALTHCARE | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215 24 9691 | 1☐ M 2☒ F | 76 Yrs. | | | Jan. 23, 1925 | West Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4204 Curtis Avenue | 21226 | U.S. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7th | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Earl Miller | Sara Miller |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Joseph Principio | 4204 Curtis Avenue Baltimore, Maryland 21226 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Cedar Hill Cemetery | 8/28/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Shannon Liggett | Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ISCHEMIC CARDIOMYOPATHY | 1 MONTH |
| Due to (or as a consequence of): | b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 1 YEAR |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Louisa Appea MD | 14441 | August, 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LOUISA APPEA - DANDUSH, 900 CATON AVE, BALTIMORE

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Brenda B Sparks |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME HEETER, MARIE

10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#29d PER PHY G798 8/31/01JH

# Certificate of Death

Reg. No. 2001 27313

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month | Day | Year | 3. Tima of Death |
|---|---|---|---|---|
| Elizabeth A. Howley | 8 | 26 | 2001 | 7:00 A.M |

| 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Locust Lodge - 184 Meadow Rd. | Pasadena | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Yaar) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 214-24-6741 | 1☐ M 2☑ F | 94 Yrs. | | | 7-10-07 | MD |

Usual Residence of Decedent

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MD | Anne Arundel | Pasadena | 1☑ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of What Country? |
|---|---|---|
| 184 Meadow Rd. | 21122 | USA |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) | 14. Rece - American Indian, Black, Whita, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced | 1☐ Yas 2☑ No If Yes, Give Year or Dales: | 1☐ Yes 2☑ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5 | | Housewife | OWN — Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Nama (First, Middle, Maiden Sumame) |
|---|---|
| George Zellinger | Lena Rodenberg |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Vincent H. Howley, Son | 2405 Warbler Crt., Murrells Inlet, SC 29576 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cematery, crematory or othar place) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☑ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify) | Sacred Heart | 8-29-01 | Balto., MD |

| 21. Signature of Funeral Service Licensee | 22. Nama and Address of Facility |
|---|---|
| ▶ Jerome Gonce | George J. Gonce Funeral Home, P.A. 4001 Ritchie, Highway Baltimore, Maryland 21225 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused tha death. Do not enlar tha moda of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one causa on each lina.

| | | Approximate Interval Between Onsat and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebro Sclerosis Cardio Vascular Disease | |
| Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of dalivary Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fatel death 3☐ Ectopic pregnancy 4☐ Pregnant at tima of death 5☐ Othar (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

| 23a. Did tobecco usa contributa to tha causa of death? | 24a. Was an autopsy performed? | 24b. Wara autopsy findings availabla prior to completion of causa of death? |
|---|---|---|
| 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☑ No | 1☐ Yas 2☐ No |

| 25. Was case referred to medical examiner? | 26. Placa of Daath (Check only one) |
|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 8☑ Other (Specify) Assisted Living |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yas 2☐ No | |
| | 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, deta end placa, and dua to tha cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinlon, daeth occurred at tha tima, date and place, and due to the cause(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D 42820 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christopher de Borja MD 3708 Mountain Rd. Pasadena, MD 21122

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#29d

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27314

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Yaar | 3. Time of Death |
|---|---|---|
| Evelyn Anna Hanssen | August 24 2001 | 9:40A M |

| 4a. Facility Nama (If not institution, giva street and number) | 4b. City, Town, or Location of Daath | 4c. County of Deeth |
|---|---|---|
| Franklin Square Hospital Center | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Numbar | 6. Sex | 7. Aga (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 215-05-5458 | 1☐M 2☒F | 89 Yrs. | | | July 28, 1912 | Maryland |

Usuel Residance of Decedent

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of What Country? |
|---|---|---|
| 2500 Gray Manor Terrace | 21222 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - American Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Giva Yaar or Dates: | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grada compiated) | | 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 7th. Grade | | Receptionist | Ice Company |

| 17. Fethar's Nama (First, Middle, Last) | 18. Mothar's Neme (First, Middle, Maiden Sumame) |
|---|---|
| John Frederick Timmerman | Mary Roppelt |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) |
|---|---|
| William Hanssen/Husband | 2500 Gray Manor Terrace Baltimore MD 21222 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Nama of cematary, crematory or othar placa) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify) | Holly Hill Cemetery | 8/27/2001 | Baltimore MD 21222 |

| 21. Signatura of Funeral Servica Licensee | 22. Nama and Address of Facility |
|---|---|
| ▶ | John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206 |

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa or complicetions that caused tha deeth. Do not anter the mode of dying, such as cerdiec or respiratory errest, shock, or haart failure. List only ona ceusa on aach lina.

| | | Approximate Intervel Between Onsat and Death |
|---|---|---|
| Immediate Cause (Final disaasa or condition rasulting in daath) | a. Septic Shock | 2 days |
| Sequentially list conditions, if any, taading to immediata causa. Enter Underlying Cause (Disaasa or injury thet initiated evants rasulting in daath) Last | Due to (or as a consequence of): b. Generalized Peritonitis | |
| | Dua to (or as a consequence of): c. Ischemic Colitis | |
| | Dua to (or as a consequence of): d. Colon Cancer | |

| IF FEMALE: 23b. Wes decedent pregnant in tha past 12 months? | 23c. If yes, outcoma of pragnancy | 23d. Data of dalivary Month Day Year |
|---|---|---|
| 1☐Yas 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of deeth 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying ceusa given in Part I.

| 23a. Did tobacco use contributa to tha ceusa of death? | 24a. Was an autopsy performed? | 24b. Ware autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yas 2☒No | 1☐Yas 2☐No |

| 25. Wes cese refarred to madical examiner? | 26. Place of Daath (Check only ona) | |
|---|---|---|
| 1☐Yas 2☒No | Hospitel: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Homa 5☐Rasidance 8☐Other (Specify) |

| 27. Manner of Daath | 28a. Date of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yas 2☐No | |
| | 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) | | | 28f. Location (Streat and Numbar or Rural Route Number, City or Town, Stata) |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To tha bast of my knowledga, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated.
2☐**Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha ceusa(s) and mennar stated.

| 29b. Signature and title of certifier | 29c. Licensa numbar | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D37612 | August 24, 2001 |

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print)
Dr. Mohamed Alabrash 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

| 31. Data filad (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Penny D Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Medical Certification;**

Hassen, Evelyn

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27315

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|---|---|
| John | J. | Hammen Jr. | August 23, 2001 | 12:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 707 George Avenue | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-34-3689 | 1☒M 2☐F | 64 Yrs. | | | July 17, 1937 | Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 707 George Avenue | 21221 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Machine Operator | Western Electric |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John J. Hammen | Mary Hrica |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Adelaide Hammen wife | 707 George Avenue, Essex, Md. 21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sacred Heart of Jesus | August 27 2001 | Dundalk, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, Md. 21222 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Renal Cell Carcinoma | 3 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D45390 | August 24th, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NYO MIN (M.D.) 8114 SANDPIPER CIRCLE #211, BALTIMORE, MD 21236

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27316

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VALERIE ANN HUFFMAN

2. Date of Death: Month Aug. Day 22 Year 2001

3. Time of Death: 2329

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 217-74-7823

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 3, 1959

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 201 Hall Hgwy

10f. Zip Code: 21817

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housekeeping

16b. Kind of Business/Industry: nursing home

17. Father's Name (First, Middle, Last): Elliott Lester Morgan

18. Mother's Name (First, Middle, Maiden Surname): Miriam Frances Smith

19a. Informant's Name/Relationship (Type, Print): Peninsula Regional Medical Ctr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 E. Carroll Street Salisbury, MD 21801

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple sclerosis — 18 yrs

Due to (or as a consequence of):

b. Sepsis cardiac death — 24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: John R McLean MD

29c. License number: D25209

29d. Date signed (Month, Day, Year): 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R. McLean MD 1315 South Division St. Salisbury Md. 21804

**State Registrar**

31. Data filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8/24/01 9329

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VALERIE HUFFMAN #217-74-7893 4/4

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27317

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Norma Jean Iaconis

2. Date of Death Month Day Year: August 23, 2001

3. Time of Death: 11:50AM

4a. Facility Name *(If not institution, give street and number)*: 1234 Kahler Avenue

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 386-18-5103

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6-11-1926

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1234 Kahler Avenue

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ink Inspector

16b. Kind of Business/Industry: Lord Baltimore Press

17. Father's Name *(First, Middle, Last)*: Raymond Taylor

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Hulderman

19a. Informant's Name/Relationship *(Type, Print)*: Steve Argabright/Grandson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 505 Nanticoke Court Abingdon MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn Cemetery

Date: 8/25/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Steve Cvach

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Hyperlipidemia.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P A Baltatzis MD

29c. License number: D0028949

29d. Date signed *(Month, Day, Year)*: 8/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Panayiotis A. Baltatzis M.D. 8113 Harford Road Ste. 100 Baltimore MD 21234

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#1 per phys G798 082801 SS **Certificate of Death** Reg. No. 2001 27318

Kitting

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

#1

12

## Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Wanda M. Kitting~~ Wanda M. Kitting
2. Date of Death: Month August Day 25 Year 2001
3. Time of Death: 9:45 PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

## Funeral Director

5. Social Security Number: 214-22-1955
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 78 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 12, 1923
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 207 Highland Rd
10f. Zip Code: 21060
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Alexander Thomas Wagner
18. Mother's Name (First, Middle, Maiden Surname): Sara Ellen Zimmerman

19a. Informant's Name/Relationship (Type, Print): Polly Bingel /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Highland Road, Glen Burnie, MD 21060

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Aug 28 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

## Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such es cerdiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. OBSTRUCTION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as e consequence of):
b. CEREBRO VASCULAR ACCIDENT.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of daath 5☐Othar (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No
28. Place of Daath (Chack only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Neturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurrad at tha time, data and place, and dua to tha cause(s) and mennar es stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 45149
29d. Date signed (Month, Day, Year): August 25 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): ONABATO 301 - Hospital Drive Glen Burnie MD 21061

## State Registrar

31. Data filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27319

Nancy Lee Kurtz

Patient known as Nancy Kurtz

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Nancy Kurtz | August 26, 2001 | 2312 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore | N/A |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-34-1434 | 1☐ M 2☒ F | 63 Yrs. | | | MAY 30, 1938 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 259 Rupert Circle | 21225 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Melvin Diggs | Mary Adlee Lewis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert Kurtz - husband | 259 Rupert Circle, Baltimore, Md. 21225 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Baltimore Washington Crm. | 8/30/01 | Laurel, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Mary K. Marshall | Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aneurysm Rupture | 1 minute |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | P# 8957 | August 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tec Chang MD Sinai Hospital

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27320

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ERMA ELIZABETH KUSZMAUL
2. Date of Death (Month, Day, Year): AUGUST 24, 2001
3. Time of Death: 7:30 A.M.
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE CROMWELL
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 217-14-1384
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/14/1921
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: baltimore
10c. City, Town or Location: RIDGELEIGH
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1872 YAKONA ROAD
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAFETERIA MANAGER
16b. Kind of Business/Industry: BALTIMORE COUNTY SCHOOL SYSTEM

17. Father's Name (First, Middle, Last): ALEXANDER T. HARLFINGER
18. Mother's Name (First, Middle, Maiden Surname): MARTHA SHANE

19a. Informant's Name/Relationship (Type, Print): WILLIAM S. KUSZMAUL, JR. SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 HYACINTH ROAD CARNEY, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM. GAR.
Date: 8/28/01
20c. Location - City or Town, State: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage CVA | weeks |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery Disease, ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Marina C. Raymundo, MD
29c. License number: D54518
29d. Date signed (Month, Day, Year): 8/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha Raymundo 3007 E. Northern Parkway Baltimore MD 21214

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature ▶ Spanks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27321

LINDA KOPPENHAVER August 26 2001 0455A
Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Linda May Koppenhaver
2. Date of Death — Month: August Day: 26 Year: 2001
3. Time of Death: 4:55am
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-48-7258
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb.19,1946
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7944 Landsdale Road
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Jewerly Manager
16b. Kind of Business/Industry: K-Mart

17. Father's Name *(First, Middle, Last)*: Christopher Barr
18. Mother's Name *(First, Middle, Maiden Surname)*: Hedwig Wilson Harka

19a. Informant's Name/Relationship *(Type, Print)*: James Koppenhaver /husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7944 Landsdale Road Baltimore MD 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory — Date: 8/29/01
20c. Location - City or Town, State: Baltimore MD

21. Signeture of Funeral Service Licensee: R. Terry Connelly
22. Name end Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic cancer — 5 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley MD
29c. License number: D25205
29d. Dete signed *(Month, Day, Year)*: August 26, 2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001
32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27322

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Joseph John Kahn

2. Date of Death Month Day Year: Aug. 22, 2001

3. Time of Death: 8:30pm

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 083-05-2018

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 23, 1913

9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5458 Gloucester Road

10f. Zip Code: 20144

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Systems Analyst

16b. Kind of Business/Industry: Mutual of New York

17. Father's Name *(First, Middle, Last)*: Irving Kahn

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Irene Stevens

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Kahn- wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5458 Gloucester Rd.,Columbia, Md. 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Vet. Cemetery

Date: Aug.27, 2001

20c. Location - City or Town, State: Crownsville, MD.

21. Signature of Funeral Service Licensee: Kyle Schlaman MDSD

22. Name and Address of Facility: Witzke Funeral Home of Columbia 5555 Twin Knolls Road, Columbia, Maryland 21045

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence I Silverberg

29c. License number: MD 22076

29d. Date signed *(Month, Day, Year)*: 8-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence I. Silverberg 9380 Baltimore Nat'l Pike Ellicott City MD 21042

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: Eugene D Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27323

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| MICHAEL | | KUBIN | 08 | 24 | 2001 | 1:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1115 Old Eastern Avenue Apt A | Essex | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 218-64-4900 | 1☒M 2☐F | 47 Yrs. | | | | | Apr.29,1954 | Md |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Essex | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1115 Old Eastern Avenue Apt A. | 21221 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Asst. Manager | Safeway grocery St. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Joseph F. Kubin | Ada Goley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Natalie Kubin wife | 1115 Old Eastern Avenue, Essex,Md.21221 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sacred Heart of Jesus | August 27 2001 | Dundalk,Md. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Connelly Funeral Home of Dundalk,P.A. 7110 Sollers POint Rd. Dundalk,Md.21222

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. STAPHYLOCOCCAL SEPSIS WITH MULTIPLE ORGAN | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): FAILURE<br>b. BURKITT'S LIKE NON HODGKIN LYMPHOMA | 3 months |
| | Due to (or as a consequence of): WITH MENINGEAL INVOLUGMENT AND CHEMOTHERAPY<br>c. | |
| | Due to (or as a consequence of):<br>d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD (Chronic Obstructive Pulmonary Disease)

Polyneuropathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D51555 | 08/24/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SEIN AUNG, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MD 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #26 PER VERB.G798 8/31/01 JH

# Certificate of Death

Reg. No. 2001 27324

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner** — **Funeral Director** — **To Be Completed by Funeral Director**

| | | | | |
|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Mildred R. Kettell | | | 2. Date of Death (Month, Day, Year): August 24, 2001 | 3. Time of Death: 11PM M |
| 4a. Facility Name (If not institution, give street and number): Morningside House of Ellicot City | 4b. City, Town, or Location of Death: Ellicot City | 4c. County of Death: Howard | | |
| 5. Social Security Number: 213-05-4523 | 6. Sex: 1☐M 2☒F | 7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year): June 24, 1913 |
| 9. Birthplace (State or Foreign Country): Maryland | | | | |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7014 Holabird Ave. | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Assistant | Banking |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Tunstall | Minnie M. Braugham |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William Gable son in law | 9820 Old Annapolis Rd. Ellicot City Md. 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Parkwood Cem. | Aug29 2001 | Parkville Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 |

**Physician /Medical Examiner** — **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Colon Cancer | 2 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) ASSISTED LIVING |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | 000529 28 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY ANNE NIDIRY 1792 Merritt Blvd. Baltimore Md 21222

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27325

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Edward Kurtz, III
2. Date of Death Month Day Year: August 26, 2001
3. Time of Death: 10:00 am M
4a. Facility Name *(If not institution, give street and number)*: 4237 Slater Avenue
4b. City, Town, or Location of Death: Perry Hall
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-24-8337
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 10, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4237 Slater Avenue
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify: Korean
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): 2 yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technical Manager
16b. Kind of Business/Industry: Bell Communication Research

17. Father's Name *(First, Middle, Last)*: William Edward Kurtz, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Maude Drebing

19a. Informant's Name/Relationship *(Type, Print)*: Joyce D. Kurtz/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4237 Slater Avenue Baltimore, Maryland 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gds. of Faith Cemetery
Date: 8/29/01
20c. Location - City or Town, State: Overlea, Maryland

21. Signature of Funeral Service Licensee: Earl L. Canapp, CFSP
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — Due to (or as a consequence of): — Mon Ths

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D53722
29d. Date signed *(Month, Day, Year)*: Aug 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY J. PILLING, MD GOOD SAM HOSPITAL, BALTIMORE

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001
32. Registrar's Signature: Penny B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27326

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norman E. Krebs, Sr.

2. Date of Death (Month, Day, Year): August 25, 2001

3. Time of Death: 6:50 A.M.

4a. Facility Name (If not institution, give street and number): 3021 Fourth Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-01-2867

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-12-1916

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3021 Fourth Ave.

10f. Zip Code: 21234

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Howard Johnson 'S Ice Cream Plant

17. Father's Name (First, Middle, Last): William Krebs

18. Mother's Name (First, Middle, Maiden Surname): Pauline Barth

19a. Informant's Name/Relationship (Type, Print): Mrs Margaret Krebs (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3021 Fourth Ave., Baltimore, Maryland 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gards. Date: 8-28-01

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks Jr

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PARKINSON'S & LEWY BODY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D32639

29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Herlihy M.D. 7801 York Rd. 101-A Towson MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: ▶ Penny D. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27327

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| EDITH | ANNA | KOLKER | August 26, 2001 | 12:05 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Villa St. Michael Nursing Home | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 077-28-6884 | 1☐ M 2☒ F | 91 Yrs. | | | Apr. 23, 1910 | Canada |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4800 Seton Dr. | 21215 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Registered Nurse | Nursing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Newbery | Anna Burgess |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Phillip Kolker/son | 3505 Taney Rd. Baltimore, MD 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Hilltop Service Corp. | 8/28/01 | Towson, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic obstructive pulmonary Disease | 15 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☑ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Dehydration

| 23e. Did tobacco use contribute to the causa of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown | 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D30377 | Aug 27, 01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Cooper MD 6503 Park Heights Ave Balt MD 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Barbara G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27328

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LEO FRANCIS LOPPATTO

2. Date of Death Month AUGUST Day 22, Year 2001

3. Time of Death: 6:30 AM.

4a Facility Name *(If not institution, give street and number)*: 6736 HUNTER ROAD

4b. City, Town, or Location of Death: ELKRIDGE

4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 079-12-1130

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 10, 1916

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3370 OLD LINE AVENUE

10f. Zip Code: 20724

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: MILITARY

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name *(First, Middle, Last)*: ADAM DOBKIEWICZ

18. Mother's Name *(First, Middle, Maiden Surname)*: SOPHIE LOPPATTO

19a. Informant's Name/Relationship *(Type, Print)*: FULTON LOPPATTO - SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10416 EWELL AVE., KENSINGTON, MD. 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cem.

Date: 8/30/01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Myk. Marlatt

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Md. 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart feilure. List only one cause on aach lina.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMATOSIS

Dua to (or as a consequence of):

b. GASTRIC ADENOCARCINOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last

Due to (or as e consequence of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* DAUGHTER'S RESIDENCE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: (DC) 10198

29d. Date signed *(Month, Day, Year)*: AUGUST 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALTER REED ARMY MEDICAL CENTER EDWARDA M. BUDA-OKREGLAK, MD. 6900 GEORGIA AVENUE, WASHINGTON, D.C. 20307

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

01-4817-027
CJ
Lucia Lancaster

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 100201: ITEMS #23a, 27, 28a-f per ME G800 ss

# Certificate of Death

Reg. No. 2001 27329

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|
| Lucia | Lancaster | August | 22 | 2001 | 07:57 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (in yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 216-04-0392 | 1☐ M 2☒ F | 22 Yrs. | | | | | 04/10/1979 | MD. |

Usual Residance of Decedant

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Baltimore | Monkton | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizen of What Country? |
|---|---|---|
| 15156 Manor Road | 21111 | U.S.A |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas: | 1☐ Yas 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highast grada completed) | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | Never Worked | UNKNOWN |

| 17. Father's Nama (First, Middla, Last) | 18. Mothar's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Lancaster | Candida Gould |

| 19a. Informant's Name/Raletionship (Type, Print) | 19b. Meiting Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) |
|---|---|
| Candida Lancaster/Mother | 15156 Manor Road Monkton MD. 21111 |

| 20a. Mathod of Disposition | 20b. Place of Disposition (Nama of cematary, crematory or othar place) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify) | Holy Ghost Church Cemetery | 08/25/01 | Issue, Maryland |

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home Of Dulaney Valley Inc. 10 W. Padonia Rd. Timonium Md. 21093

**Physician /Medical Examiner**

23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart faitura. List only one cause on aach tina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in deeth)

a. DROWNING COMPLICATING DRUG INTOXICATION AND ALCOHOL USE

Dua to (or as a consequence ot):

Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

b.

Dua to (or as a consequence ot):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of daath? |
|---|---|
| 1☒ Yes 2☐ No | 1☒ Yas 2☐ No |

| 25. Was casa raferred to medicat examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yas 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☒ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined | Found: 8-22-01 | Found: 7:00a M | 1☐ Yas 2☒ No | Unknown |

| 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) | 28t. Location (Street and Number or Rural Routa Number, City or Town, State) |
|---|---|
| Swimming Pool | Murray Hill Rd., Columbia, MD |

29a. Cartifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of examinetion and/or investigetion, in my opinion, daath occurred at the tima, data and place, and dua to tha causa(s) and mannar steted.

| 29b. Signatura and titla of certifier | 29c. Licansa number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| Jack M. Titus, M.D. | O.C.M.E. | August 23, 2001 |

30. Nama and addrass ot person who completed causa of deeth (Item 23a) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Geneva D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27330

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Louise Laing
2. Date of Death (Month, Day, Year): August 25, 2001
3. Time of Death: 1:30PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-40-8066
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 8, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 324 St. Georges Road
10f. Zip Code: 21221
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: XX
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William P. Blake, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Jennie A. Elmo

19a. Informant's Name/Relationship (Type, Print): Jennie McDonnell Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Tidewater Dr. Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial
Date: 8/29/01
20c. Location - City or Town, State: Eldersburg, MD

21. Signature of Funeral Service Licensee: Lynn B. Henss
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland21211

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. SCLERODERMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020 AUGUST 25, 2001 1:30 p.m.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARY LAING

6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27332

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOLORES LORETTA LESTER

2. Date of Death (Month, Day, Year): August 22 2001

3. Time of Death: 6:30 a M

4a. Facility Name (If not institution, give street and number): 624 OAK COURT

4b. City, Town, or Location of Death: ABERDEEN

4c. County of Death: HARFORD CO

**Funeral Director**

5. Social Security Number: 142-12-5849

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 11 1919

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD CO

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 624 OAK COURT

10f. Zip Code: 21001

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK

16b. Kind of Business/Industry: HARFORD CO PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): CLARENCE GORDON

16. Mother's Name (First, Middle, Maiden Surname): VIOLA TUCKER

19a. Informant's Name/Relationship (Type, Print): Timothy E. Lester/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 Oak Court, Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT CALVARY U.A.M.E.

Date: 08-27-01

20c. Location - City or Town, State: ABERDEEN, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD, 321 S PHILADELPHIA BLVD P.A.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 1 year

Due to (or as a consequence of):

b. Emphysema — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — 5 years

Due to (or as a consequence of):

d. Hypoxia — 5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas M Fitzpatrick MD

29c. License number: D42742

29d. Date signed (Month, Day, Year): 08-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas M. Fitzpatrick,MD., Walter Reed Army Medical Cntr 6825 16th St. N.W. Wash.DC 20012

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27331

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| ALLAN | LURIA | AUGUST 23 2001 | 7 10 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| NORTHWEST HOSPITAL | RANDALLSTOWN | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-20-9661 | 1 [X] M 2 [ ] F | 74 Yrs. | | | July 12, 1927 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Randallstown | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9804 Plowline Road | 21133 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Civil Engineer | Kaiser Engineering |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry Luria | Ethel Camplan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Ann Luria Wife | 9804 Plowline Road; Randallstown, Maryland 21133 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Lake View Mem. Park | 8/25/2001 | Sykesville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE INFERIOR MYOCARDIAL INFARCTION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [X] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA, ATRIAL FIBRILLATION, RUE ISCHEMIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ C. Mavi | D17333 | AUGUST 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C MAVI MD NHC, BALTO MD 21133

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Geneva M Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27333

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Carroll Logue, Sr.

2. Date of Death (Month, Day, Year): August 21, 2001

3. Time of Death: 9:47 AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-38-7673

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/4/1941

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 353 Townsend Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Diesel Mechanic

16b. Kind of Business/Industry: Trucking

17. Father's Neme (First, Middle, Last): John A. Logue

18. Mother's Name (First, Middle, Maiden Surname): Lelia Schilling

19a. Informant's Name/Relationship (Type, Print): JoAnn Dietz-Logue/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 353 Townsend Road Baltimore MD 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Garden of Faith Cem.

Date: 8/25/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Ventricular Tachycardia | 15 minutes |
| Due to (or as a consequence ot): b. | Ventricular Fibrillation | 10 minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Myocardial Infarction | 2 Hours |
| Due to (or as a consequence ot): d. | Ischemic Cardiomyopathy | 10 years |

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] MD Deputy

29c. License number: D18667

29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP MILITELLO, MD Shock Trauma 22 S. Greene St. Baltimore, Md 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #3 PER PHY G798 8/31/01 JH

# Certificate of Death

Reg. No. 2001 27334

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Walter | Latham | August 22 2001 | 1:00am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 20 Box Hill South Pkwy #111 | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 201-07-3273 | 1☒ M 2☐ F | 83 Yrs. | | | Jan 6, 1918 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Belair | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 20 Box Hill South Pkwy #111 | 21009 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yas, Give Year or Dates: '38-41 '45-47 | 1☐ Yas 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | sales | automotive parts |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| William Thorpe Latham | Anna Dora Schrader |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Walter Latham Jr/son | 1901 Brinson Rd T8 Lutz, FL 33549 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, cramatory or other piece) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify) | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haert feilura. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. myocardial infarction | immediate |
| Due to (or as a consequence of): | b. coronary artery disease | decades |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. congestive heart failure | decades |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Julie Tinney MD | D53186 | August 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julie Tinney MD 615 W. McPhail Rd Bel Air, MD 21014

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Donna D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#3

Walter B. Latham 8-22-01

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27335

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Peter Mario Marchesani

2. Data of Death Month: AUG. Day: 26, Yaar: 2001

3. Time of Death: 9:31 P M

4a. Facility Nama (If not institution, giva street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 142-32-3568

6. Sex: 1☐M X 2☐F

7. Aga (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): APR. 30, 1941

9. Birthplece (Stata or Foraign Country): New Jersey

Usual Residence of Decedent

10a. Stata: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 8404 Montpelier Drive

10f. Zip Coda: 20708

10g. Citizan of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yes, Giva Year or Dates: 1961-63

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☐No X Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highast grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Sales

16b. Kind of Business/Industry: Cosmetics

17. Father's Name (First, Middle, Last): Frank Marchesani

18. Mother's Nama (First, Middle, Maiden Sumama): Lena Maroni

19a. Informant's Name/Relationship (Type, Print): Bernadette Marchesani - wife

19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code): 8404 Montpelier Drive, Laurel, Md. 20708

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar placa): Meadowridge Mem. Pk.

Data: 8/30/01

20c. Location - City or Town, Stata: Elkridge, Md.

21. Signatura of Funeral Service Licensee: Mark Marshall

22. Nama and Addrass of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

**Physician /Medical Examiner**

23a. Part I. Entar tha diseasa, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only ona cause on each lina.

Approximata Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 1 yr.

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac Arthythmia — 3 yrs.

Dua to (or as a consequenca of):

c. Diabetis Mellitus — 3 yrs.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☐No 9☐Unknown

23c. If yas, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at tima of daath 5☐Other (specify) 9☐Unknown

23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

Hyperlrprdomia

23e. Did tobacco use contributa to tha causa of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2☐No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Wes case referred to medical examiner? 1☐Yas 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Rasidenca 8☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one) 1☒Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☐Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signature and titla of certifier: Manejwala

29c. Licensa number: D13671

29d. Data signad (Month, Day, Yaer): 8/26/01

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print): B. G. Manejwala, MD 14201 Laurel Park Dr., Laurel, Md. 20707

**State Registrar**

31. Date filed (Month, Day, Yaar): AUG 28 2001

32. Registrar's Signatura: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27336

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Rose Marie Montour | | | | | | 2. Data of Death Month Day Year: August 26, 2001 | | 3. Time of Death: 9:00 A M |
| 4a. Facility Name (If not institution, give street and number): 1508 Seling Avenue | | | 4b. City, Town, or Location of Daath: Rosedale | | | 4c. County of Death: Baltimore | | |
| 5. Social Security Number: 216-28-5682 | 6. Sex: 1☐M 2☒F | 7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | | 8. Data of Birth (Month, Day, Year): February 16, 1931 | | 9. Birthplace (State or Foraign Country): Maryland |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State: Maryland | 10b. County: Baltimore | 10c. City, Town or Location: Rosedale | | | | | | 10d. Inside City Limits: 1☐Yes 2☒No |
| 10e. Street and Number: 1508 Seling Avenue | | | 10f. Zip Code: 21237 | | | 10g. Citizan of What Country?: USA | | |
| 11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | | 12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐Yas 2☒No Specify: | | | 14. Raca - Amarican Indian, Black, White, atc.: Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Administrator | | | 16b. Kind of Business/Industry: Schooling | | |
| 17. Father's Name (First, Middle, Last): Antonio Pedro Poggi | | | 18. Mother's Name (First, Middle, Maiden Sumame): Mary Magdelina Del Grosso | | | | | |
| 19a. Informant's Name/Relationship (Type, Print): Mr. Lance Montour- Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1508 Seling Avenue Baltimore, Maryland 21237 | | | | | |
| 20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | | | 20b. Place of Disposition (Nama of cematary, cramatory or other place): Oaklawn Cemetery | | Data: 8/30/01 | 20c. Location - City or Town, State: Baltimore Maryland | | |
| 21. Signature of Funeral Service Licensee: Christina L. Hilton | | | 22. Nama and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 | | | | | |

Physician /Medical Examiner

RR

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. — Approximata Interval Betwaan Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cancer of right lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Other (specify) 9☐Unknown

23d. Dare of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: Terminal Stage of Cancer

23e. Did tobacco usa contributa to the causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Placa of Daath (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Rasidance 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledga, daath occurred at the tima, date and place, and dua to the causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at tha tima, data and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. Licansa number: D03607

29d. Data signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michele Cerino 7600 Osler Drive Towson, Maryland

RC 25

State Registrar

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Amend Item4b

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

PER FH G798 08/28/01 RR

# Certificate of Death

Reg. No. 2001 27337

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ROSE Mc Million

2. Date of Death: Month AUGUST Day 23 Year 2001

3. Time of Death: 1200 NOON

4a. Facility Name (If not institution, give street and number): 4600 Sandwood Road

4b. City, Town, or Location of Death: ~~Spatterns Point~~ Edgemere

4c. County of Death: Baltimore Co.

**Funeral Director**

5. Social Security Number: 216-14-3674

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1921

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4600 Sandwood Road

10f. Zip Code: 21219

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐Yes 2☒No Specify:

14. Rece - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 Years; College (1-4or 5+):

18a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Michael Teslar

18. Mother's Neme (First, Middla, Maiden Surneme): Kathryn Jerome

19a. Informant's Name/Reletionship (Type, Print): Mr. John H. McMillion (Husband)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4600 Sandwood Road Edgemere, Maryland 21219

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crametory or othar place): Oak Lawn Cemetery

Dete: 8/28/2001

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Fecility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused tha death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Myocardial Infarction — Weeks

Due to (or es a consequence of):

b. Coronary Artery Disease/Recurrent Infarction — Years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension, Ischemic Cardiomyopathy

Diabetes, CVA, Cellulitis

Pemphereal Vaccular Diseace

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Mennar of Death: 1☒Netural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date snd piece, snd due to the cause(s) snd menner steted.

29b. Signature and title of certifier: Ilene, MD

29c. License number: D 37089

29d. Date signed (Month, Day, Year): AUGUST 23 2001

30. Nema and address of parson who completed cause of deeth (Item 23a) (Type, Print): ILENE BROWNER 5505 Hopkins Bayview Circle Baltimore, Maryland

**State Registrar**

31. Data filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Brenda D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

RR

RR 10

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-4809-005

ANTHONY MANDLEY

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 100301:ITEMS#23a,27,28a-f per ME G800-gs

# Certificate of Death

Reg. No. 2001 27338

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Anthony Mandley

2. Data of Death — Month: AUGUST Day: 21 Year: 2001

3. Time of Death: 7:57P.M.

4a. Facility Name *(If not institution, give street and number)*: 404 KATHERINE AVE

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 406-21-7578

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 18 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 12-11-82

9. Birthplace *(State or Foreign Country)*: KY

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yas 2 ☐ No — XX

10e. Street and Number: 5 F. Sharondale Way

10f. Zip Coda: 21221

10g. Citizan of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 X No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☐ No XX *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12th Grade — Collega (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Electrician

16b. Kind of Businass/Industry: Company

17. Fathar's Nama *(First, Middle, Last)*: Terry Mandley

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Evangeline Crocker

19a. Informant's Name/Ralationship *(Type, Print)*: Evangeline Crocker

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5 Sharondale Way Apt.#F Baltimore, MD. 21221

20a. Mathod of Disposition: 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or other piece)*: Roosevelt Mem. Pk. Cem. — Data: 08-28-01

20c. Location - City or Town, Stata: Chesapeak, VA

21. Signature of Funaral Service Licensee: Jerome A. Thompson

22. Nama and Addrass of Facility: Baltimore, Maryland 21215 — WM.C.March FH, West 4300 Wabash Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the daath. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervel Between Onsat and Death

Immediata Cause (Final disaasa or condition resulting in daath)

a. DROWNING

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in tha underlying ceusa given in Part f.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 X Yas 2 ☐ No

26. Placa of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☐ Residence 6 X Othar *(Specify)* CREEK

27. Mannar of Death: 1 ☐ Natural 2 X Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending Investigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*: Found: 8-21-01

28b. Tima of Injury: Unknown M

28c. Injury at Work? 1 ☐ Yas 2 X No

28d. Describa how injury occurrad: Subject drowned

28a. Placa of Injury - At home, farm, street, factory, office building, atc. *(Specify)*: Found: in water

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*: 404 Katherine Ave. Essex, Baltimore County, MD

29a. Cartifiar *(Check only one)*: 1 ☐ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2 X **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: J. M. T.

29c. Licansa number: O.C.M.E.

29d. Data signed *(Month, Day, Year)*: AUGUST 22,2001

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Jack M. Titus, M.D. — 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signatura: D. Sparks

DHMH 16 Rav 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27339

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth Eileen MCCartney

2. Date of Death (Month, Day, Year): August 24, 2001

3. Time of Death: 1412

4a. Facility Name (If not institution, give street and number): Saint Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 214-40-6689

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCt. 3, 1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1106 Lisadale Court- Apt.1-C

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Nurse practioner

16b. Kind of Business/Industry: Bon Secour Hospital

17. Father's Name (First, Middle, Last): Thomas Joseph McCartney

18. Mother's Name (First, Middle, Maiden Surname): Ruth Elizabeth McDonald

19a. Informant's Name/Relationship (Type, Print): Mary Carol Gary- Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 Kent Avenue, Catonsville, Md. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Memorial Park

Date: 08/29/2001

20c. Location - City or Town, State: Sykesville, MD.

21. Signature of Funeral Service Licensee: Heather Brown

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, Md. 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. Coronary Artenosclerotic Vascular Disease Unkown

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Dua to (or as a consequance of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to tha causa(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Bergeson MD.

29c. License number: D0053849

29d. Date signed (Month, Day, Year): August 24, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Scott Bergeson St. Agnes Hospital 900 Caton Ave Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**NAME** MCCARTNEY, RUTH EILEEN

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27340

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Nancy Rusy Mould | August 26, 2001 | 1:20A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 339-28-6822 | 1☐M 2☒F | 68 Yrs. | | | April 2, 1933 | Illinois |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Gaithersburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 100 Kent Square Road | 20878 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| | 4 | Research Assistant | Washington International Center |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lyman Rusy | Erna Arendt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thomas M. Mould/Husband | 100 Kent Square Road Gaithersburg, MD 20878 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory, Inc. | 8/27/01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward A. Gregorchik | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximeta Interval Between Onset and Death

| | | |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Ovarian Cancer | 2yrs |
| Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☑No 3☐Probably 4☐Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was casa referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐**Medicat Examinar:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Frederick H Barr MD | D22775 | 8-26-01 |

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
Frederick G. Barr, M.D. 4545 Wisconsin Avenue, Ste. 1345, Chevy Chase, MD 20815

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27341

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Edward McClure

2. Date of Death Month: August Day: 22 Year: 2001

3. Time of Death: 5:06PM

4a. Facility Name (If not institution, give street and number): 322 Stonewall Road

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 200-14-6439

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 27, 1927

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 322 Stonewall Road

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1945-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Steel Corporation

17. Father's Name (First, Middle, Last): William McClurg

18. Mother's Name (First, Middle, Maiden Surname): Elsie Menke

19a. Informant's Name/Relationship (Type, Print): Jeanne McClurg/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 322 Stonewall Road Catonsville, MD 21228

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 8-24-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovasc/AR Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Edward McClure MD

29c. License number: D11171

29d. Date signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EPW/Lawson Sorg 3933 St Johns Lane Ellicott City, Maryland 21042

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27342

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Risto Mattila

2. Date of Death (Month, Day, Year): August 23, 2001

3. Time of Death: 5:10 PM

4a. Facility Name *(If not institution, give street and number)*: 709 Maiden Choice Lane RGT107

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 017-05-3822

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR 14, 1921

9. Birthplace *(State or Foreign Country)*: Finland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 709 Maiden Choice Lane RGT107

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1945-1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Coast Guard Captain

16b. Kind of Business/Industry: U. S. Coast Guard

17. Father's Name *(First, Middle, Last)*: Anton Hjalmar Mattila

18. Mother's Name *(First, Middle, Maiden Surname)*: Augusta Kohl

19a. Informant's Name/Relationship *(Type, Print)*: David K. Mattila/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1036 Provincetown, MA 02657

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. | Date: 8-25-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstruct Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47447

29d. Date signed *(Month, Day, Year)*: August 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew LaFris 711 Maiden Choice Lane Catonsville Maryland

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: Jennie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 27343
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Regina T. McCulloch | AUGUST 26, 2001 | 09:00 A |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Saint Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 257-60-9527 | 1☐M 2☒F | 92 Yrs. | | | AUG 14, 1909 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5913 Bellona Avenue | 21212 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 2 | School Teacher | Public Schools |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas W. Tunney | Anna Callan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Constance McCulloch /daughter | 5913 Bellona Avenue Baltimore, MD 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory | 08/27/01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George E. MacNabb | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CEREBROVASCULAR THROMBOSIS | 5 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CHRONIC ATRIAL FIBRILLATION | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Joginder P Mehta M.D | D 41410 | August 26th, 2001. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27344

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Joseph Edward McFaul | AUGUST 27 2001 | 10:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-42-1715 | 1☒M 2☐F | 59 Yrs. | | | MAR 22, 1942 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 605 South Robinson Street | 21224 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 1962-66 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Sales Management | Communications |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John E. McFaul | Alma V. Appel |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lisa Freistat / daughter | 605 South Robinson St. Baltimore, MD 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory, Inc. | 8/28/01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| George E. MacNabb | Cremation Society of Md., Inc. 299 Frederick Road Baltimore, MD 21228 |

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myelodysplasia | years |
| | Due to (or as a consequence of): Metastatic disease. | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Cachexia.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | 15504 | 8.27.01. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

McFAUL, ~~JOHN~~ JOSEPH

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27345

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Florence McComb | August 22, 2001 | 5:37 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Union Memorial Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-20-1889 | 1☐ M 2☒ F | 75 Yrs. | | | Jan. 11, 1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 400 N. Rose Street | 21224 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James Thomas | Lucy (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Brenda McComb (Daughter-Law) | 6710 Athol Avenue Elkridge, MD 21075 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Cedar Hill Cemetery | 8/24/01 | Brooklyn, Marland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Shannon Liggett | Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOXIC ENCEPHALOPATHY — 90 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 26c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Sharell Mason Medical Doctor | AT 24389 46 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/218
Sharell Mason Medical Doctor 201 East University Parkway Baltimore, Maryland

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27346

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Timothy D. Orem
2. Date of Death (Month, Day, Year): August 25, 2001
3. Time of Death: 12:20 PM
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218 36 9790
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 3, 1940
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 810 Union Avenue
10f. Zip Code: 21211
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Traffic Coordinator
18b. Kind of Business/Industry: Highs of Baltimore

17. Father's Name (First, Middle, Last): David C. Orem
18. Mother's Name (First, Middle, Maiden Surname): Ethel Mae Krout

19a. Informant's Name/Relationship (Type, Print): Elizabeth L.Orem (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 810 Union Avenue, Baltimore, MD 21211

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem
Date: 8/30/01
20c. Location - City or Town, State: Cockeysville, MD

21. Signature of Funeral Service Licensee: Walter J. Henss
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, INC 3631 Falls Road, Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CANCER, METASTATIC
Approximate Interval Between Onset and Death: 18 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: G M
29c. License number: D27730
29d. Date signed (Month, Day, Year): 8/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Geneva D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27347

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DELORES W. POWELL

2. Date of Death: Month August Day 19 Year 2001

3. Time of Death: 2:25 AM

4a. Facility Name (If not institution, give street and number): CHAPEL HILL NURSING CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-20-9703

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 15 1921

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1 TOKAY COURT

10f. Zip Code: 21133

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

18b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): BENJAMIN WICKS

18. Mother's Name (First, Middle, Maiden Surname): LILLIAN SCOTT

19a. Informant's Name/Relationship (Type, Print): Charles H. Powell/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Tokay Ct, Randallstown, Md., 21133

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 08-24-01

20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

**Physician /Medical Examiner**

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multi infarct Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gargzene Right foot

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25112

29d. Date signed (Month, Day, Year): 8/21/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TAHOORA KAWAJA 20 Cross Roads Dr. Suite 101 Owings Mills MD 21117

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

Medical Certification; To be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27348

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| NANNIE PIERCE | AUG. 26, 2001 | 4:41am M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GARDEN VIEW NURSING HOME | BALTIMORE | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-03-5055 | 1☐ M 2☒ F | 88 Yrs. | | | 4-25-1913 | SC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | BALTIMORE | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 30 S. ATHOL AVE. | 21227 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: AFRICAN AMERICAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9th | 0 | DOMESTIC | HOME |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ANDERSON McNEIL | FLORENCE KENDALL |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RUTH JOHNSON (daughter) | 322 N. HILTON STREET BALTIMORE, MD 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | ARBUTUS MEMORIAL PARK 8/30/01 | ARBUTUS, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | WYLIE FUNERAL HOME P.A. 638 N. GILMOR ST. BALTIMORE, MD 21217 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Alzheimers Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Dementia | |
| | Due to (or as a consequence of): c. High blood pressure | |
| | Due to (or as a consequence of): d. peripheral arterial disease | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D24476 | 08/27/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NISHA SOPPE, MD 2300 Garrison Blvd Balto MD 21216

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] D Sparks |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27349

Perry, Emil

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Emil Forrest Perry | AUGUST 21 2001 | 8:58P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 001-03-8715 | 1☒ M 2☐ F | 82 Yrs. | | | NOV 14, 1918 | Vermont |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Ellicott City | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9857 Diversified Lane | 21042 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☒ Yes 2☐ No 1941-1967 | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5 + | Military | Air Force |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Forrest Orin Perry | Julia Nourie |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Teresa Moller/Daughter | 9857 Diversified Lane Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metro Crematory Inc. | 8-23-01 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Thomas Gregor | Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 |

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bilateral Pneumonia — 3d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Alzheimer's Disease — 10 yrs.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month / Day / Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| 25. Was case referred to medical examiner? 1☐ Yes 2☒ No | 28. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) |
|---|---|

| 27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred |
|---|---|---|---|---|
| | | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D55942 | 8/22/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAM FOSTER, MD 6565 N. CHARLES #203 BALTIMORE MD 21212

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Penny D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#20b PR. F.H. & 30 PR. DVR G798 8-28-01 JAB

# Certificate of Death

Reg. No. 2001 27350

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Joseph Pozzuoli | August 22, 2001 | 6:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ESther Place | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-7205 | 1☒ M 2☐ F | 78 Yrs. | | | 1/16/1923 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5054 Erdman Avenue | 21205 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Merchant Seaman | Maritime |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Domonic Pozzuoli | (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Louis Pozzuoli/Brother | 2207 Pelham Avenue Baltimore, Maryland 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Sacred Heart of ~~Jesus~~ MARY | 8/25/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ | John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Hypertension | 720 yrs |
| | Due to (or as a consequence of): c. Atherosclerotic cardiovascular Disease | |
| | Due to (or as a consequence of): d. Diabetes Mellitus | 720 years |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) Assist Living |

| 27. Manner of Death | 28a. Date of injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Everett MD | MD46444 MD | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NINA FRANCES EVERETT ESTHER PLACE BALTIMORE MD.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Jessica D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 27351

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Michael Perholtz
2. Date of Death — Month: August Day: 21 Year: 2001
3. Time of Death: 3:30p.m.
4a. Facility Name *(If not institution, give street and number)*: Franklin Woods Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 169-03-1347
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/19/1914
9. Birthplace *(State or Foreign Country)*: Czechoslovakia

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5701 Trumps Mill Road
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer
16b. Kind of Business/Industry: Jeffersonian Newspaper

17. Father's Name *(First, Middle, Last)*: John Perholtz
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Hanzel

19a. Informant's Name/Relationship *(Type, Print)*: Kenneth Perholtz/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5701 Trumps Mill Road Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith
Date: 8/25/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Staphylococcus bacteremia due to

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. dysphagia

Due to (or as a consequence of):
d. Stroke

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus, ileus, pressure ulcers, hypertension, carotid artery stenosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of Certifier: [signature] Tom Edmondson MD
29c. License number: D45766
29d. Date signed *(Month, Day, Year)*: August 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tom Edmondson, MD, 9105 Franklin Square Dr., Ste 312, Baltimore, MD 21237

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEMS #24a, 27, 28b&c PER ME C799 9/07/01 JH

Reg. No. 2001 27352

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): YVONNE A PATTERSON

2. Date of Death Month: AUGUST Day: 25 Year: 2001

3. Time of Death: 0920 AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 155-16-7606

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July13,1922

9. Birthplace (State or Foreign Country): N.J.

Usual Residence of Decedent

10a. State: Md.

10b. County: Worchester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9400 Condo Unit 2103

10f. Zip Code: 21842

10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Actress

18b. Kind of Business/Industry: Broadway

17. Father's Name (First, Middle, Last): Carl Bornshine

18. Mother's Name (First, Middle, Maiden Surname): Agnes Mcandrew

19a. Informant's Name/Relationship (Type, Print): Yvonne Adair niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5838 Fitzhugh St. Burke Va. 22015

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Mem. Park

Date: Aug. 28 2001

20c. Location - City or Town, State: Paramus New Jersey

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers pOint Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 7 DAYS

Immediate Cause (Final disease or condition resulting in death): a. ACCIDENTAL SUBDURAL HEMATOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☐~~Natural~~ 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): AUGUST 17 2001

28b. Time of Injury: UNKNOWN M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: FALL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NURSING HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): BERLIN NURSING HOME BERLIN, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: T48375

29d. Date signed (Month, Day, Year): 8.25.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAX WEINMANN, M.D. UNIVERSITY HOSP. 22 S. GREENE ST BALTO. MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 27353

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| BETTY PERRYMAN | August 24, 2001 | 5:00 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northwest Hospital Medical Center | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-18-6696 | 1☐M 2☒F | 74 Yrs. | | | 10/23/1926 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Reisterstown | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 301 Church Road | 21136 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 th | | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jesse Blackburn | Catherine Snyder |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harvey W. Perryman Jr. son | 4320 White Oak Ct Hampstead MD 21074 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Carroll Cremation Ser. | 8/26/01 | Hampstead, MD |

21. Signature of Funeral Service Licensee: Ronald B Eline

22. Name and Address of Facility: 11824 Reisterstown Road
Eline Funeral Home Reisterstown Md 21163

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. GI Bleed | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiac Ischemia
Esophageal Ulcer.
Aspiration Pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | D44505 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AJ TAPERIAL, JR. MD — NWHC

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Donna B. Sparks |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27354

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Matilda | Margaret | Roye | August | 24, | 2001 | 9:25 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Good Samaritan Hospital | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 213-01-6512 | 1☐ M 2☒ F | 95 Yrs. | | | | | September 23, 1905 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3510 Bellevale Avenue | 21206 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th Grade | N/A | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| August Gajewski | Walerya Cyrska |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kenneth D. Pezzulla/Personal Representative | 401 Washington Avenue Suite 301 Towson MD 21204 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Most Holy Redeemer | 8/27/01 | Baltimore Maryland |

| 21. Signature of Funeral Service Licensee | Christina L Hilton | 22. Name and Address of Facility |
|---|---|---|
| ▶Christina L. Hilton | | Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urosepsis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶Marina Protopapas D.O. | AT-243-8934-619 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marina Protopapas Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Roye, Matilda MA

RR

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27355

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Aloysius Ryan
2. Date of Death (Month, Day, Year): August 26th 2001
3. Time of Death: 11:30 PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 215-30-2977
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 29, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8403 Bayberry Rd
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Line Supervisor
16b. Kind of Business/Industry: Black & Decker

17. Father's Name (First, Middle, Last): Thomas Ryan
18. Mother's Name (First, Middle, Maiden Surname): Camilla Amass

19a. Informant's Name/Relationship (Type, Print): Geraldine L. Ryan
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8403 Bayberry Rd. Baltimore Md 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph Ceme Date: Aug. 30 2001
20c. Location - City or Town, State: Fullerton, Md
21. Signature of Funeral Service Licensee: Keisha S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Renal failure — days

Due to (or as a consequence of):
b. Sepsis — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHF

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0056632
29d. Date signed (Month, Day, Year): August 26th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5601 Loch Raven Blvd Baltimore, MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Bonnie D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27356

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Reino Erick Rahikka

2. Date of Death Month Day Yaar: August 26, 2001

3. Time of Death: 2:30 pm

4a. Facility Nama *(If not institution, giva street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 140-09-6174

6. Sax: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: DEC 18, 1914

9. Birthplaca *(State or Foraign Country)*: New York

Usual Residence of Dacedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Numbar: 717 Maiden Choice Ln., ST616

10f. Zip Coda: 21228

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Give Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Spacify only highest grade complatad)*: Elementary/Secondary (0-12): Collega (1-4or 5+): 5+

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Engineer / Manager

16b. Kind of Businass/Industry: Telephone Manufacturing

17. Fathar's Nama *(First, Middla, Last)*: Erkki Rahikka

18. Mother's Nama *(First, Middla, Maidan Surnama)*: Hilda Maria Junnikkala

19a. Informant's Name/Ralationship *(Type, Print)*: Mary S. Rahikka / wife

19b. Mailing Addrass *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 717 Maiden Choice Ln., ST616 Catonsville, MD 21228

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Nama of cametary, crematory or other placa)*: Metro Crematory, Inc. Data: 08/28/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funeral Service Licensa: Edward A. Gregorchik
Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Md., Inc.
299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. End Stage Dementia — years
Due to (or as a consaquance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in death) Last
b. Due to (or as a consaquance of):
c. Due to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa raferrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [X] Nursing Homa 5 [ ] Rasidanca 8 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 8 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only ona)*: 1 [X] **Certifying Physician**: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, date and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: Andres Salazar MD

29c. Licansa number: D51051

29d. Date signed *(Month, Day, Yaar)*: August 27, 2001

30. Nama and addrass of parson who complatad causa of daath (item 23a) (Type, Print): Andres Salazar 711 Maidenchoice Lane Catonsville, MD, 21228

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: AUG 28 2001

32. Registrar's Signatura: D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that tha death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Name: Reino Rahikka

20

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27357

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HELEN REED.

2. Date of Death: Month AUGUST Day 23 Year 01

3. Time of Death: 12.00 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSP CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 218-28-5404

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1932

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2020 Holborn Rd.

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Charles John Parrish

18. Mother's Name (First, Middle, Maiden Surname): Marie Fisher

19a. Informant's Name/Relationship (Type, Print): Chris Reed son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1532 Park Ln. Pasadena Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Garrison Forest

Date: Aug.30 2001

20c. Location - City or Town, State: Owings Mills

21. Signature of Funeral Service Licensee: John E. Mullen Jr.

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE — 1 HOUR

Due to (or as a consequence of):

b. ISCHAEMIC CARDIOMYOPATHY. — 5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CONGESTIVE CARDIAC FAILURE — 5 YEARS.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES. MELLITUS.

RENAL INSUFFICIANCY.

SACRAL STAGE IV DECUBITUS ULCER

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shadaba INTERNAL MEDICINE PGY-1

29c. License number: RES000.

29d. Date signed (Month, Day, Year): AUGUST 24 01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): DR. SHADABA ASAD. 3001 SOUTH HANOVER ST BALTIMORE 21225 MD.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Jennifer D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

AUG 2 8 2001

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Amend Item 1- For State Registrar 31 PER DVR G798 08/28/01 RR

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2001 27358

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| JOHN ROGERS SR | AUGUST | 25 | 2001 | 0020hr M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS BAYVIEW MEDICAL CENTER | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-20-4414 | 1☑M 2☐F | 74 Yrs. | | | 12/03/1926 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7826 East Collingham Dr. | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 yrs. | | Mechanic | American Can |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward John Rogers | Margaret Jacobs |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lewin Rogers brother | 13124 Miles Rd. Chase Md. 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Bayview Crematory | Aug. 27, 2001 | Baltimore |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobecco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☑Unknown | 1☐Yes 2☑No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| DR WEN WEE MA | 22010 | 8/25/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNS HOPKINS BAYVIEW MEDICAL CENTER

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| 8/25/2001 | AUG 28 2001 Bruce B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27359

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Rest

2. Date of Death: Month Aug Day 24 Year 2001

3. Time of Death: 345AM

4a. Facility Name (If not institution, give street and number): Lorien Nursing House

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 213-09-6125

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 25, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicot City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 10233 Green Clover Dr.

10f. Zip Code: 21042

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Textile Worker

16b. Kind of Business/Industry: Textiles

17. Father's Name (First, Middle, Last): John Rest

18. Mother's Name (First, Middle, Maiden Surname): Effie Easten

19a. Informant's Name/Relationship (Type, Print): Mr. Larry T. Rest

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10233 Green Clover Dr. Ellicott City, Maryland 21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Crest Lawn Memorial Gardens

Date: 08/27/01

20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Timothy S. Hamm NO1113

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. sepsis — 2days

Due to (or as a consequence of):

b. pneumonia — 3weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gary Kaz MD

29c. License number: D41617

29d. Date signed (Month, Day, Year): Aug 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kazlow MD 10805 Hickory Ridge Rd Columbia Md 21044

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27360

Marjorie Sinton August 26 2001, 9:45AM

Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| | |
|---|---|
| 1. Decedent's Name (First, Middle, Last) | Marjorie Rupp Sinton |
| 2. Date of Death (Month, Day, Year) | August 26, 2001 |
| 3. Time of Death | 9:45 AM |
| 4a. Facility Name (If not institution, give street and number) | Gilchrist Center for Hospice Care |
| 4b. City, Town, or Location of Death | Towson |
| 4c. County of Death | Baltimore |
| 5. Social Security Number | 212-28-6357 |
| 6. Sex | 1☐M 2☒F |
| 7. Age (In yrs. last birthday) | 71 Yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hrs.: Hours / Min. | |
| 8. Date of Birth (Month, Day, Year) | April 2, 1930 |
| 9. Birthplace (State or Foreign Country) | Maryland |
| **Usual Residence of Decedent** | |
| 10a. State | MD |
| 10b. County | Baltimore |
| 10c. City, Town or Location | Towson |
| 10d. Inside City Limits | 1☐Yes 2☒No |
| 10e. Street and Number | 12 Hampshire Woods Court |
| 10f. Zip Code | 21204 |
| 10g. Citizen of What Country? | United States |
| 11. Marital Status | 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced |
| 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 1☐Yes 2☒No |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 1☐Yes 2☒No |
| 14. Race - American Indian, Black, White, etc. Specify: | White |
| 15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12) | |
| College (1-4or 5+) | 4 |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | Public Health Nurse |
| 16b. Kind of Business/Industry | Baltimore County |
| 17. Father's Name (First, Middle, Last) | Clarence L. Rupp |
| 18. Mother's Name (First, Middle, Maiden Surname) | Alberta Holt Joyce |
| 19a. Informant's Name/Relationship (Type, Print) | DR. William A. Sinton, Jr./husband |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 12 Hampshire Woods Court., Towson, MD 21204 |
| 20a. Method of Disposition | 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) | Chesapeake Crematory |
| Date | 8/27/01 |
| 20c. Location - City or Town, State | Beltsville, MD |
| 21. Signature of Funeral Service Licensee | [signature] |
| 22. Name and Address of Facility | Cremation and Funeral Alternatives 8717 Green Pastures DR., Towson, MD 21286 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pancreatic cancer | One year |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| | | |
|---|---|---|
| 29b. Signature and title of certifier | H. Anthony Riley, MD | |
| 29c. License number | D25205 | |
| 29d. Date signed (Month, Day, Year) | August 26, 2001 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204 | |
| 31. Date filed (Month, Day, Year) | AUG 28 2001 | |
| 32. Registrar's Signature | [signature] | |

**State Registrar**

DHMH 16 Rev 6/95

RR

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#14 per fh G798 083101 SS **Certificate of Death**

Reg. No. 2001 27361

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| LUIS | SERRANO | 08 / 24 / 2001 | 0825 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE, MARYLAND | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-84-5463 | 1 [X] M 2 [ ] F | 85 Yrs. | | | Jan 4, 1916 | Bolivia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Parkville | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8429 Old Harford Road, Apt. A | 21234 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No | 1 [X] Yes 2 [ ] No Specify: Bolivian | Specify: ~~Hispanic~~ White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Dentist | Private Practice |
| | 5+ | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jose Luis Serrano | Isolina Echegaray |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anna Sanz /Daughter | 11996 Long Lake Drive, Owings Mills, MD 21136 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Chesapeake Crematory | Aug 27 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] M00982 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | P14413 | 08-24-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOAN CHANG, DO 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MARYLAND

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | [signature] Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27362

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Kathryn Margaret Sofsky

2. Date of Death (Month, Day, Year): Aug. 28, 2001

3. Time of Death: 4:15 AM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-18-4036

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 18, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 East Joppa Rd Apt 808

10f. Zip Code: 21286

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unknown

16b. Kind of Business/Industry: Cafeteria

17. Father's Name *(First, Middle, Last)*: Edward J. Hunt

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Elizabeth Adams

19a. Informant's Name/Relationship *(Type, Print)*: Marietta Sofsky / daughter in law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3208 Canterbury Lane., Fallston, MD 21047

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 8/29/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 8/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

AUGUST 28, 2001 4:15 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

KATHERYN SOFSKY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #30 PER DVR G798 8/30/01 JH

# Certificate of Death

Reg. No. 2001 27363

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Jessica Sloan | 8 | 15 | 2001 | 23:00 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Mercy Medical Center | Baltimore | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | Days | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| none | 1☐M 2☒F | Yrs. | | | | 7 | 8 15 2001 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 17 Nutmeg North #B | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| none | none | none | none |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Stanford Stanberry | Teayarnna Sloan |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mercy Medical Center | 301 St. Paul Place Baltimore, MD 21203 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Extreme Prematurity | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month | Day | Year |
|---|---|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 8 | 15 | 01 |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☒No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | D29299 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYRUS JEFFERSON LAWYER MERCY MEDICAL CENTER 301 SAINT PAUL ST. BALTO.MD 21202

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#30

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27364

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Doris Salkauskas
2. Date of Death: Month August, Day 25, Year 2001
3. Time of Death: 10:30A.M.
4a. Facility Name (If not institution, give street and number): 2 N. Belle Grove RD
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-09-8211
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 12/20/1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 N. Belle Grove Rd
10f. Zip Code: 21228
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Austin Joseph Miller
18. Mother's Neme (First, Middle, Meiden Surname): Anna Brown

19e. Informent's Name/Reletionship (Type, Print): John Salkauskas/Husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2 N. Belle Grove RD Baltimore, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Baltimore National Cem. Dete: 08/28/01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funerel Service Licensee: Bernard Salkauskas
22. Neme and Address of Fecility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onset end Deeth |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC BREAST CANCER | 5 YEARS |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last | b. | |
| | Due to (or es e consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D42680
29d. Dete signed (Month, Dey, Yeer): AUGUST 27, 2001

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): SARA SHEKIT M.D 9051 BALTIMORE NATIONAL PIKE, STE 4C, ELLICOTT CITY MD 21042

**State Registrar**

31. Dete filed (Month, Dey, Yeer): AUG 28 2001
32. Registrar's Signeture: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27365

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Philip | Dolian | Smith | August 23 2001 | 12:47 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Franklin Square Hospital | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 246-66-6119 | 1☐M 2☐F XX | 58 Yrs. | | | 01-25-43 | NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 54 Stillwood Circle | 21236 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed XX 4☐Divorced | 1☐Yes 2☒No XX If Yes, Give Year or Dates: | 1☐Yes 2☒No XX Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th Grade | NA | Roofer | Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph SMith | Amanda Brooks |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sharon-Thomas Parker | 2820 Paper Mill Road Phoenix, MD 21131 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Valley Cem. | 08-28-01 | Baltimore Co, MD |

21. Signature of Funeral Service Licensee: Lorna A Thompson

22. Name and Address of Facility: Baltimore, Maryland 21215 WM.C.March FH, West 4300 Wabash Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Respiratory Failure | 2 Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Lung Cancer | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | P 15686 | 08/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Lana Rigby 9000 Franklin Square Dr. Baltimore Md 21237

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Deputy D Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Philip Smith

RR

RR 10

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27366

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Quentin Austin Seiss | August 23, 2001 | 9:50 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3213 Greenway Drive | Ellicott City | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-12-6728 | 1 X M 2 F | 77 Yrs. | | | MAY 23, 1924 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Howard | Ellicott City | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3213 Greenway Drive | 21042 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 X Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Oil Burner Maintenance | Oil Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Willis Seiss | Ora Jane Saylor |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruth B. Seiss/Wife | 3213 Greenway Drive Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Blue Ridge Cemetery | 8-28-01 | Thurmont, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Edward A. Gregorchik | MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Severe obstructive lung disease — 20 yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 X No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart failure
Diabetes mellitus

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Thomas Finucane | D24334 | August 24, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS FINUCANE MD Johns Hopkins Geriatrics Center

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Geneva G Sparks |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8PER FH G799 9/19/01 JH

# Certificate of Death

2001 27367
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| NICHOLAS A STANLEY | AUGUST 26 2001 | 1915 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNIVERSITY OF MARYLAND | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 213 72 2859 | 1☒M 2☐F | 42 Yrs. | | | | | Aug. 6, ~~1959~~ 1957 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5920 Johnnycake Road | 21207 | U.S. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Yaar or Datas: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | Laborer | Steelworkers Iron Worker |

| 17. Fathar's Name (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maiden Surname) |
|---|---|
| Robert N. Stanley | Rose E. Brown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| A. Maria Stanley / Sister | 25 Poplar Avenue Catonsville, Maryland 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other placa) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify) | Woodlawn Cemetery | 8/30/2001 | Baltimore, Maryland |

| 21. Signatura of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Jerome Gonce | Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

| | | Approximata Intarval Batween Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PNEUMONIA/SEPSIS | 2 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. SQUAMOUS CELL CANCER HEAD/NECK | 5 months |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcoma of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditfona** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of causa of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yas 2☒No |

| 25. Was case referred to medical examiner? | 26. Placa of Death (Chack only ona) |
|---|---|
| 1☐Yas 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify) |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datermined | | M | 1☐Yas 2☐No | |

| 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Streat and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and placa, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and placa, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Andrews MD | P13356 | AUGUST 26, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEATHER ANDREWS 22 South Greene St. Baltimore MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27368

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EVELYN SMITH
2. Date of Death: Month AUGUST Day 25 Year 2001
3. Time of Death: 3:16 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212 44 6892
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 16 W. Talbott Street
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William H. Greene
18. Mother's Name (First, Middle, Maiden Surname): Irene M.

19a. Informant's Name/Relationship (Type, Print): Theresa Betch / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Adair Court Joppatown, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: 8/29/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shannon Leggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RESPIRATORY FAILURE
DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: S. Rajakumar PGY I
29c. License number: AS244161 4A7$
29d. Date signed (Month, Day, Year): August 25 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr RAJAKUMAR HARBOR HOSPITAL 3001 S HANOVER ST BALTIMORE MD 21225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-4835-510

SARAH

SAFCHUCK

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27369

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sara T. Safchuck

2. Date of Death: Month AUGUST Day 23, Year 2001

3. Time of Death: 4:04P.M.

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 197-22-6803

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): July23,1929

9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 822 Jaydee Ave.

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Elmer Ashbaugh

18. Mother's Name (First, Middle, Maiden Surname): Sarah Wampler

19a. Informant's Name/Relationship (Type, Print): Larry Safchuck son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 Arbor Ct. Edgewood Md. 21040

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cem. Date: Aug.27 2001

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? INSPECTION 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): AUGUST 24,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27370

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mary E. Shifflett
2. Date of Death (Month, Day, Year): August 24, 2001
3. Time of Death: 1:00 PM
4a. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 214-26-2574
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 10, 1902
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7744 Baltimore Annapolis Blvd.
10f. Zip Code: 21060
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Household

17. Father's Name *(First, Middle, Last)*: Bernard B. Hamrick
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan E. Meeks

19a. Informant's Name/Relationship *(Type, Print)*: Susan Nadine Haislip (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7744 Balt. Ann. Blvd. Glen Burnie, Md. 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Cemetery
Date: 8/27/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home PA
3111 Mountain Rd. Pasadena, Md.21122

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Heart Disease — 10+ yrs

Due to (or as a consequence of):
b. gout.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive Heart failure.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other *(Specify)* Hospice House

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D14136
29d. Date signed *(Month, Day, Year)*: 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DALJIT S. SAWHNEY
Suite 201 Crain Towers Glen Burnie Md 21061.

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27371

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edith Satterfield
2. Date of Death: Month Aug, Day 26, Year 2001
3. Time of Death: 12:05 Am
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 217-24-3318
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): NOV. 25, 1927
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1007 E. NORTHERN PARKWAY
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: HEALTH

17. Father's Name (First, Middle, Last): STEVE SATTERFIELD
18. Mother's Name (First, Middle, Maiden Surname): NANNIE PITTS

19a. Informant's Name/Relationship (Type, Print): RUTH BOOKER/AUNT
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1007 E. NORHTERN PWKY, BALTO., MD 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro
Date: 8/27/2001
20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: James G. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 21217

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Sepsis | 7days |
| Due to (or as a consequence of): b. | Pneumonia | 14 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P15811
29d. Date signed (Month, Day, Year): Aug, 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sherman Reeves M.D, Mercy Medical Center.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Brenda G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 27372

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: SAMUEL E. SNYDER

2. Date of Death Month Day Year: AUGUST 22,2001

3. Time of Death: 12:55P

4a Facility Name *(If not institution, give street and number)*: CUMBERLAND MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 213-24-6501

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 10, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 730 Furnace Street

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk; College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: helper

16b. Kind of Business/Industry: tobacco/cigar

17. Father's Name *(First, Middle, Last)*: Samuel E. Snyder Sr

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Easton

19a. Informant's Name/Relationship *(Type, Print)*: Charles Butler/nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 98 Lavale Blvd Lavale, MD 21502

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 2 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — 10 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE, DEMENTIA, SUBDURAL HEMATOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SNYDER, SAMUEL 213 24 6501

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shiv Khanna

29c. License number: D0054004

29d. Date signed *(Month, Day, Year)*: 8/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHIV C. KHANNA, JOHNSON HEIGHTS MEDICAL BLDG. CUMBERLAND, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001

32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27373

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): David B. Trimble
2. Date of Death Month Day Year: Aug. 24, 2001
3. Time of Death: 1230 P M
4a. Facility Name (If not institution, give street and number): 13339 Fork Rd.
4b. City, Town, or Location of Death: Baldwin
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-40-2187
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 26 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baldwin
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13339 Fork Rd
10f. Zip Code: 21013
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): service director
16b. Kind of Business/Industry: Heritage Chrysler

17. Father's Name (First, Middle, Last): Charles Edward Trimble
18. Mother's Name (First, Middle, Maiden Surname): Eileen Krouse

19a. Informant's Name/Relationship (Type, Print): Ingrid Trimble wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13339 Fork Rd Baldwin, Md 21013

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel
Date: Aug 25 2001
20c. Location - City or Town, State: Forest Hill Md

21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

**Physician /Medical Examiner**

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon E Simon MD
29c. License number: D53156
29d. Date signed (Month, Day, Year): 8-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): Dr John Simon 3346 Paper Mill Rd Phoenix Md 21131

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Bonnie B Hoke

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27374

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PAUL MARTIN THALHEIMER

2. Date of Death (Month, Dey, Year): AUGUST 27, 2001

3. Time of Death: 0146 A.M.

4a. Facility Name (If not institution, give street and number): GILCHRIST CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-18-3243

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 2/9/1922

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4100 N CHARLES STREET APT. 806

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN

16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): JOSEPH THALHEIMER

18. Mother's Name (First, Middle, Maiden Surname): MARIE GERAGHTY

19a. Informant's Name/Relationship (Type, Print): CATHERINE C. THALHEIMER WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4100 N. CHARLES ST. APT. 806 BALTIMORE, MD 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MOST HOLY REDEEMER CEM.

Date: 8/30/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. mesothelioma — months

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier ▶ W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Dey, Year): August 27, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBBC 6701 N. Charles St. Balto. MD 21204

**State Registrar**

31. Date filed (Month, Dey, Year): AUG 28 2001

32. Registrar's Signature ▶ Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Paul M. Thalheimer August 27, 2001 0146 A

PR

8+1

RR

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27375

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Peter Thomas

2. Date of Death (Month, Day, Year): August 22, 2001

3. Time of Death: 6:50 P.M.

4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 212-58-2712

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 16, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 602 South Quail Street

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

16b. Kind of Business/Industry: Painting Company

17. Father's Name (First, Middle, Last): Michael Thomas

18. Mother's Name (First, Middle, Maiden Surname): Isabel Patragas

19a. Informant's Name/Relationship (Type, Print): Isabel Thomas (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 South Quail Street Baltimore, Maryland 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 8/25

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert J. Modack Jr.

22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Md 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death): a. non small cell lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Timothy J. Kang MD

29c. License number: D57458

29d. Date signed (Month, Day, Year): 8/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Kang MD Dept Fm 29 S. Paca St. Baltimore MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

6:50pm - Walk Jerk Ct.

8-22-01

Peter Thomas

#

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMEND ITEMS #8,10e&19b PERFH G798 8/31/01 JH

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27376

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edna E. Terhell

2. Date of Death Month Day Year: August 26, 2001

3. Time of Death: 9:05 PM

4a. Facility Name (If not institution, give street and number): Genesis Hamilton Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 523-18-5044

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/16/~~1916~~ 1906

Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: ~~5322~~ 5302 Kenwood Avenue

10f. Zip Code: 21206

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Henry Terhell

18. Mother's Name (First, Middle, Maiden Surname): Olive Westbrook

19a. Informant's Name/Relationship (Type, Print): Glennys R. Wise/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~5322~~ 5302 Kenwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 8/29/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] M10052

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Dementia — Approximate Interval Between Onset and Death: 6 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D45475

29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohammad Rahnama MD 8100 Harford Road Baltimore, Maryland 21234

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD
01-4637-510
JASPER
TATE

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27377

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Jasper Tate
2. Dete of Death — Month: AUGUST; Day: 13; Year: 2001
3. Time of Death: 6:30P.M.
4a. Facility Name *(If not institution, give street and number)*: 2110 HOMEWOOD AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 579-76-2070
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthdey)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 17 1955
9. Birthplace *(State or Foreign Country)*: UNKNOWN

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2110 Homewood Avenue
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1974-1976
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: UNKNOWN
16b. Kind of Business/Industry: UNKNOWN
17. Father's Name *(First, Middle, Last)*: UNKNOWN
18. Mother's Name *(First, Middle, Meiden Sumame)*: UNKNOWN
19a. Informant's Neme/Reletionship *(Type, Print)*: Veterans Administration
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 31 Hopkins Plaza, Federal Bldg. Baltimore,MD.21201
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland Veterans Cem. — Date: Aug. 23 2001
20c. Location - City or Town, State: Crownsville, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic Cardiovascular disease

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes; Hyper cholesterolemia; Schizophrenia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: AUGUST 14,2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 28 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27378

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Mary E. Voit | August 27, 2001 | 2:00 A.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Genesis Eldercare-Severna Park | Severna Park | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-34-5493 | 1☐M 2☒F | 86 Yrs. | | | March 3, 1915 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Harmens | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 Hanford Drive | 21077 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unknown | | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Thomas Woodfall | unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thomas P. Voit (son) | 7 Hanford Drive Harmens, Maryland 21077 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | 8/28/2001 | Beltsville, Maryland |

21. Signature of Funeral Service Licensee: Robert J Radack, J

22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Md 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 30'
Due to (or as a consequence of):
b. ARTHROSCLEROTIC CARDIOVASCULAR DISEASE — 20 yrs
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Day, Year) |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | 27. Manner of Death |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify) | 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined |

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John Shavers | D27838 | 8/27/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. John Shavers 518 Camp Meade Rd. Linthicum, Maryland 21090

**State Registrar**

| 31. Date Filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | Penny B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2Am 27 Aug 01
MARY E. VOIT

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27379

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph H. Wilson
2. Date of Death: Month August Day 25, Year 2001
3. Time of Death: 8:45PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-05-7423
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 1, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6216 Marietta Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Food Business

17. Father's Name (First, Middle, Last): Harry E. Wilson
18. Mothar's Nama (First, Middle, Maiden Surnema): Margaret K. Snyder

19a. Informent's Name/Reletionship (Type, Print): Margaret Wilson-- Sister
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6216 Marietta Avenue Baltimore, Maryland 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or othar piece): Parkwood Cemetery
Dete: 8/29/01
20c. Location - City or Town, Stete: Parkville, Maryland

21. Signature of Funeral Service Licensee: Heather Cain
22. Nama and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. MESOTHELIOMA

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or es e consequence ot):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of ceusa of death? 1 [ ] Yas 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Deeth (Check only one): Hospitet: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Menner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and dua to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Dey, Year): 8/27/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Dete filed (Month, Day, Year): AUG 28 2001
32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

AUGUST 25, 2001 8:45 p.m.

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JOSEPH WILSON

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27380

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KELVIN WESTON
2. Date of Death: Month: August Day: 21 Year: 2001
3. Time of Death: 8:50 PM
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 214-84-2392
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-09-60
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3488 Spellman Road
10f. Zip Code: 21225
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction worker
18b. Kind of Business/Industry: Construction Co.
17. Father's Name (First, Middle, Last): Nathaniel Weston
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Mayfield
19a. Informant's Name/Relationship (Type, Print): Nathaniel + Dorothy Weston
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3488 Spellman Road Baltimore, Maryland 21225
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Arbutus Mem. Pk.
Data: Cem. 08-27-2001
20c. Location - City or Town, State: Arbutus, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Acquired Immune deficiency Syndrome — 9 years

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
26c. Injury at Work? 1 ☐ Yes 2 ☐ No
26d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] (M.D)
29c. License number: B#2A - P 13473
29d. Date signed (Month, Day, Year): August, 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO HTUT, Harbor Hospital Center, 3001 South Hanover Street, Baltimore MD 21225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 27381

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LILLIE MAE WILLIAMS
2. Date of Death (Month, Day, Year): August 23, 2001
3. Time of Death: 5:35 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSP. CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 213-14-2596
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 18, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2011 Warren Avenue
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): (unknown)
18. Mother's Name (First, Middle, Maiden Surname): Lillian M. (unknown)

19a. Informant's Name/Relationship (Type, Print): Gary B. Williams (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5331 Wasena Ave. Baltimore, Maryland 21225

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8/24/01
20c. Location - City or Town, State: Beltsville, Md.

21. Signature of Funeral Service Licensee: Robert J. Modarelli Jr.
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Md 21222

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Renal Failure | 20 days |
| Due to (or as a consequence of): b. | Peripheral vascular disease | 7yrs + |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Acute Myocardial Infarction | 20 days |
| Due to (or as a consequence of): d. | Abdominal Aortic Aneurysm Resection | 23 days |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD ; Hypercholesterolemia ; MALNUTRITION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Arguillano MD
29c. License number: D28988
29d. Date signed (Month, Day, Year): August 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lino R. Arguillano MD 3001 S. Hanover St. Balt. Md 21225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: Jennifer B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27382

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLARD WEBER
2. Date of Death (Month, Day, Year): Aug 22 2001
3. Time of Death: 3:50 P.M.
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSP.
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 178-16-4648
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 1, 1921
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: PA
10b. County: Centre
10c. City, Town or Location: Howard
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 136 Pike Rd.
10f. Zip Code: 16841
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk.
18b. Kind of Business/Industry: Metal Manufacturing

17. Father's Name (First, Middle, Last): Ambrose Weber
18. Mother's Name (First, Middle, Maiden Surname): Sarah Whitman

19a. Informant's Name/Relationship (Type, Print): Ms. Beatrice Weber
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 136 Pike Rd. Howard, PA 16841

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hubleresburg Cemetery
Date: 08/25/01
20c. Location - City or Town, State: Walker Twp., Pa.

21. Signature of Funeral Service Licensee: [signature] M00530
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Respiratory failure — Approximate Interval Between Onset and Death: months

Due to (or as a consequence of): b. Pneumonia — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: coronary artery disease, anemia, spinal stenosis, myelopathy, hyperlipidemia, osteoporosis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD, FCCP
29c. License number: D 36845
29d. Date signed (Month, Day, Year): Aug 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAI-CHI NGUYEN, MD, FCCP 7350 grace Drive, Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27383

Pt known as Carrie Young

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

RR

RR 4

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carrie Young

2. Date of Death Month Day Year: August 26, 2001

3. Time of Death: 0958 M

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 215-30-9372

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-23-34

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 3855 Greenspring Avenue Apt. #123

10f. Zip Code: 21211

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): B.A.Degree

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President

18b. Kind of Business/Industry: Advance Bank

17. Father's Name (First, Middle, Last): Horace Miller

18. Mother's Name (First, Middle, Maiden Surname): Florence

19a. Informant's Name/Relationship (Type, Print): Cindy R. Scott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158: 4712 Old Hanover Road Westminster, MD.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Date: 08-27-01

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Norma A. Thompson

22. Name and Address of Facility: Baltimore, Maryland 21215 WM.C.March, West 4300 Wabash Avenue

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COPD (Chronic obstructive Pulmonary dis. ~40yrs

Due to (or as a consequence of):

b. Aortic stenosis ~20yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Congestive heart failure ~20yrs

Due to (or as a consequence of):

d. HyperTension >40yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia

23e. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Williams, MD Sinai Hospital of Baltimore

**State Registrar**

31. Date filed (Month, Day, Year): AUG 28 2001

32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27384

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Margaret Irene Zeigler | August 20 2001 | 1:30 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Agnes Hospital | BAltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 180-01-2042 | 1☐M 2☒F | 90 Yrs. | | | | | 10-06-1910 | Penna. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Catonsville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 717 Maiden Choice Lane ST 215 | 21228 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Seamtress | Textile Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Lewis Zeigler | Grace Eva Hoover |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Ahalt- sister | 717 Maiden Choice Lane- ST 215, Catonsville, Md 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Balto./Wash. Crematory | 08/25/01 | Laurel, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Kym Schlonger 20120 | Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Md. 21228 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Colon cancer | Months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Stroke | days |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in tha past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D47447 | August 24 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrea Lyles 711 Maiden Choice Lane, Catonsville, Md 21228

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 27385 Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOHN THOMAS ALBAUGH | August 9, 2001 | 3:05 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Carroll County General Hospital | Westminster | Carroll |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-03-4644 | 1 X M 2 ☐ F | 86 Yrs. | | | Aug. 12, 1914 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Keymar | 1 X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6930 Keysville Road | 21757 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW II | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2 | Restauranteur | Food Service |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles David Albaugh | Nettie M. Harman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George T. Albaugh/nephew | 2443 Mayberry Rd., Westminster, MD 21158 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Trinity Lutheran Cem. | 08/11/01 | Taneytown, MD |

21. Signature of Funeral Service Licensee: John M. Skiles M00534

22. Name and Address of Facility: Skiles Funeral Home, 136 E. Baltimore St., Taneytown, MD 21787

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Renal Failure | 7wk |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. Prostate Cancer | 10yr |
| | Due to (or as a consequence of): c. Diabetes | 34yr |
| | Due to (or as a consequence of): d. ASCVD | 25yr |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John W Middleton MD | D25443 | 8/10/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Rd, Westminster, md 21157

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | Jeanne D Sparks |

**State Registrar**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WJL 25

DHMH 17 Rev 1/2001

ORIGINAL

8/9/01
CTB 1125
adkins

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27386

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| CLIFTON | THOMAS | ADKINS | AUGUST | 9 | 2001 | 1125 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| WATERVIEW HEALTH CARE CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-36-2453 | 1☒ M 2☐ F | 81 Yrs. | | | JUNE 1, 1920 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 28180 WALLER RD | 21801 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | FARMER | OWN FARM |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| GROVER CLEVELAND ADKINS | CLARA O. HEARN |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PHILIP W. ADKINS - SON | 28081 WALLER RD. SALISBURY, MD 21801 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | PARSONS CEMETERY | 8/13/01 | SALISBURY, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ B. Keith Lynch CFSP | 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DUT

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Mahesh Moondra | D32014 | 8/11/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAHESH MOONDRA MD 106 MILFORD ST 106 B SALISBURY MD 21804

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

6DQ

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | ▶ Geneva G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27387

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FREDERICK BOSTIAN, JR.

2. Date of Death: Month AUG Day 15 Year 2001

3. Time of Death: 5:05 AM

4a. Facility Name (If not Institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

**Funeral Director**

5. Social Security Number: 579-01-4659

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 7, 1908

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: MARBURY

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5135 MARBURY RUN ROAD

10f. Zip Code: 20658

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHEET METAL WORKER

16b. Kind of Business/Industry: U.S. FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): FREDERICK BOSTIAN, SR.

18. Mother's Name (First, Middle, Maiden Surname): ANNE CURRY

19a. Informent's Neme/Relationship (Type, Print): MARION BOSTIAN-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5135 MARBURY RUN RD., MARBURY, MD 20658

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donelion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): TRINITY MEM. GARDENS

Date: 8-18-2001

20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Indersee: JOHN P. KNISLEY MO1164

22. Name and Address of Facility: HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respirstory arrest, shcck, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. ACUTE PNEUMONIA — 24 HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or aa a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

DEHYDRATION

MALNUTRITION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benjers MD

29c. License number: D-28281

29d. Dete signed (Month, Day, Year): AUGUST 15, 2001

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): NELSON V. BENJERS MD 6B INDUSTRIAL PARK DR. PRESTON SQ. II WALDORF, MD 20602

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001

32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

FREDERICK BOSTIAN

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27388

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ethel Marie Boswell

2. Date of Death (Month, Day, Year): August 12, 2001

3. Time of Death: 00:15

4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 577 07 4277

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 27, 1904

9. Birthplace (State or Foreign Country): VA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Huntingtown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1390 Emmanuel Church Road

10f. Zip Code: 20639

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurse

16b. Kind of Business/Industry: health care

17. Father's Name (First, Middle, Last): William Rinker

18. Mother's Name (First, Middle, Maiden Surname): Sarah Catherine Lindamood

19a. Informant's Name/Relationship (Type, Print): Leonard F. Reid (personal repr.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Edgewood Green Ct., Annapolis, MD 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 8-14-01

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Bilateral Lower Lobe Pneumonia — 7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

(1) Alzheimer's Disease

(2) Lung Mass

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ AT Munshi M.D. Attending Physician

29c. License number: D 19427

29d. Date signed (Month, Day, Year): 8/12/01.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANWAR MUNSHI. M.D. 110 Hosp Rd. PRINCE FREDERICK MD 20678

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27389

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ruth L. Burke

2. Date of Death: Month August Day 10 Year 2001

3. Time of Death: 10 45 AM

4a. Facility Name (If not institution, give street and number): Pleasant View Nursing Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 578-24-0728

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Mount Airy

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17226 Hardy Road

10f. Zip Code: 21771

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Nathan Thompson

18. Mother's Name (First, Middle, Maiden Surname): Gertrude Florence Price

19a. Informant's Name/Relationship (Type, Print): Charlotte A. Baudrau - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17226 Hardy Road, Mount Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 8/14/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ALZHEIMERS DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: CELLULITIS AT PEG SITE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D26499

29d. Date signed (Month, Day, Year): 8-10-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Ronald E. Miller, M.D. #4 Culwell Drive, Mount Airy, Maryland 21771

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 27390

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: John Reese Bickling

2. Date of Death: Month 08 Day 15 Year 01

3. Time of Death: 11:00 am

4a. Facility Name *(If not institution, give street and number)*: Caroline Nursing Home

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

**Funeral Director**

5. Social Security Number: 213-24-2599

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 8, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Greensboro

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 414 Bernard Ave

10f. Zip Code: 21639

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: assembly worker

16b. Kind of Business/Industry: manufacturing

17. Father's Name *(First, Middle, Last)*: John Bickling

18. Mother's Name *(First, Middle, Maiden Surname)*: Cora Tharp

19a. Informant's Name/Relationship *(Type, Print)*: George Bickling brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 414 Bernard Ave Greensboro, Maryland 21639

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Templeville Cemetery

Date: Aug 19

20c. Location - City or Town, State: Templeville, Maryland

21. Signature of Funeral Service Licensee: Stephen Fleegle

22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home PA
PO Box 160 Greensboro, Maryland 21639

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. —

Due to (or as a consequence of):

c. —

Due to (or as a consequence of):

d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Sides MD

29c. License number: D31376

29d. Date signed *(Month, Day, Year)*: 8-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Sides MD 920 Market Street Denton, Maryland 21629

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 16 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27391

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VicLA BROWN
2. Date of Death: Month August Dey 10 Year 2001
3. Time of Death: 6:45 a.m.
4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 220-68-6115
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/31/04
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 900 Booth St
10f. Zip Code: 21801
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: N/A - American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4or 5+): UNK
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNK
16b. Kind of Business/Industry: UNK

17. Father's Name (First, Middle, Last): UNK
18. Mother's Name (First, Middle, Maiden Surname): UNK

19a. Informant's Name/Relationship (Type, Print): Lucy Butler
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1504 Riverside Dr Salisbury MD 21801

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capital Cremation | Date: 8/12/01
20c. Location - City or Town, State: Dover, Del.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Brown Smith F/H 917 W Isabella St Salisbury Md. 21801

**To Be Completed by Funeral Director**

VIOLA BROWN
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D55006
29d. Date signed (Month, Day, Year): AUGUST 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohan Bhat M.D. 614 Eastern Shore Drive Salisbury Md 21804

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27392

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RICHARD FRANKLIN BALL

2. Date of Death (Month, Day, Year): August 9 2001

3. Time of Death: 1645

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 230-52-7447

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 25,1940

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: VA

10b. County: ACCOMACK

10c. City, Town or Location: MEARS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 13262 MEARS STATION ROAD

10f. Zip Code: 23409

10g. Citizen of What Country? USA

11. Merifel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REFRIGERATION SUPERVISOR

16b. Kind of Business/Industry: POULTRY INDUSTRY

17. Father's Name (First, Middle, Last): NEALY BALL

18. Mother's Name (First, Middle, Maiden Surname): BERTHA MATTHEWS

19a. Informant's Name/Relationship (Type, Print): PATRICIA BALL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 455, 13262 MEARS STATION RD., MEARS,VA 23409

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): WESSELLS CEMETERY

Date: 8/12/01

20c. Location - City or Town, State: MEARS, VA

21. Signature of Funeral Service Licensee: Paul H. Thornton

22. Name and Address of Facility: THORNTON FUNERAL HM. - PARKSLEY, VA 23421

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER — 4 MONTHS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R.L. Clinton, MD

29c. License number: D0056776

29d. Date signed (Month, Day, Year): 8/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT L. CLINTON, MD 145 E CARROLL ST SALISBURY MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: Bonnie A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

230-52-7447

Richard F. Ball

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27393

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Louise N. Boyd

2. Date of Death: Month August, Day 18, Year 2001

3. Time of Death: 12:14am

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218 44 1654

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 10, 1916

9. Birthplaca (State or Foreign Country): Massachusetts

Usual Residenca of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9003 Manordale Lane

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Nama (First, Middle, Last): William L. Newton

18. Mother's Name (First, Middle, Maiden Surnama):

19a. Informant's Neme/Relationship (Type, Print): William J. Boyd/Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 1600 Heather Heights Sykesville, MD 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or othar place): Metro Crematory

Date: 8-18-2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licansee: M01044 ▶ Shawn a Collins - Wtyle

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

August 18, 2001 12:14A

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. pancreatic cancer — 2 months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contributa to the cause of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yea 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ W. Hn Henry Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): August 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Data filed (Month, Day, Year): AUG 20 2001

32. Registrar's Signature: ▶ Donna G Sparks

Division of Vital Records, P.O. Box 68760, Louise Boyd 12:14A

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No: 2001 27394

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John E. Byron | August 18 2001 | 2:15 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 198-28-5807 | 1☒M 2☐F | 65 Yrs. | | | | | June 7 1936 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Laurel | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 11709 Balsamwood Terr | 20708 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 5+ | Electrical Engineer | Loral |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jack C. Byron | Ethel M. Lutton |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anne S. Byron/Wife | 11709 Balsamwood Terr. Laurel, MD 20708 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metropolitan Crem. | Aug 21, 2001 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Janice Marks M01103 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown | 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| P Smyles | D 42580 | August 19, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Psaujla, MD 5632 Annapolis Road #13, Bladensburg, MD 20710

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | Donna G Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

36 dad

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27395

Patient known as DOMENICK Cavalancia

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Domenick Robert Cavalancia

2. Date of Death: Month: August; Day: 13; Year: 2001

3. Time of Death: 0715 AM

4a. Facility Name (If not institution, give street and number): Sinai hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 191-14-2298

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 16, 1926

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residance of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2004B Rudy Serra Drive

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Maritat Stetus: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: WWII

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+): 5

16a. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired): Teacher

18b. Kind of Businass/Industry: Education

17. Fether's Name (First, Middle, Last): Tony Cavalancia

18. Mothar's Nama (First, Middle, Meiden Surname): Concette DiFrancesco

19e. Informent's Name/Ralationship (Type, Print): Audrey Cavalancia/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2004B Rudy Serra Drive Eldersburg, MD 21784

20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment

20b. Pteca of Disposition (Neme of cemetery, cremetory or other piece): Lakewood Mem. Gardens

Date: 8/16/2001

20c. Location - City or Town, Stete: Cheswick, PA

21. Signature of Funeral Service Licensee: J. Zumbrun

22. Name and Address of Fecility: J. N. Zumbrun F.H. & Mon. Co. 6028 Sykesville Road Eldersburg, MD 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused tha daath. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on eech line.

Immediete Causa (Final disease or condition resulting in death): a. Shock — Approximate Intarval Batween Onsetand Deeth: 1 day

Sequentially list conditions, if any, leading to immediete causa. Entar Underlying Causa (Diseese or injury that initieted events resulting in death) Last

Due to (or as a consequenca of): b. Intracerebral hematoma — 4 day

Due to (or as e consequence of): c. Atherosclerotic disease — Unknown

Due to (or es e consequence of): d. Terminal Aspiration — 1 day

tF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fatel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Dete of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

24e. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of causa of deeth? 1 [ ] Yas 2 [ ] No

25. Wes case reterred to medical examinar? 1 [ ] Yes 2 [X] No

26. Placa of Daath (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residenca 8 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 [X] Certifying Phyaician: To the best of my knowledga, daath occurrad at the time, date and place, and dua to tha cause(s) and manner as stated. 2 [ ] Medtcat Examiner: On tha basis of axaminetion and/or investigetion, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and manner stated.

29b. Signatura and titte of Certifiar: MD

29c. Licensa number: RES-000

29d. Date signed (Month, Day, Yeer): August 13 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): Tec Chang, MD 2401 W. Belvedere Ave. Baltimore, MD Sinai Hospital of Baltimore 21215

WJR 6+1 VA

**State Registrar**

31. Date filed (Month, Dey, Yeer): AUG 14 2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27396

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Leonard | | Coates | August 9, 2001 | 5:40 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Chesapeake Hospice House | Linthicum | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-70-0857 | 1[X] M 2[ ] F | 42 Yrs. | | | Aug. 24, 1958 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Shady Side | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1207 Boarman Lane | 20764 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1977-1983 | 1[ ] Yes 2[X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Financial Analyst | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| James A. Coates | Alverta Gross |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alverta Sharps/Mother | P.O. Box 574 Shady Side, MD 20764 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Crownsville Vet. Cem. | Aug. 15, 2001 | Crownsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gladys A. Sewell | Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Immune Deficiency Syndrome | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sickle Cell Trait

| 23e. Did tobacco use contribute to the causa of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown | 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) Hospice |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |

| 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1[X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Martin Weltz | D23743 | Aug. 10, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, MD 20770

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | Sandra G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-4436-033
crn
Gerald Canter

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27397

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gerald Rudolph Canter
2. Date of Death: Month August Day 05 Year 2001
3. Time of Death: 2:06 A.M.
4a. Facility Name (If not Institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 217 60 7020
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 24, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Churchton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5613 Bluebeard Court
10f. Zip Code: 20733
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter
16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): Charles Rudolph Canter
18. Mother's Name (First, Middle, Maiden Surname): Shirley Fowler

19a. Informant's Name/Relationship (Type, Print): Lisa Marie Canter, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3620 Maple Leaf Place, Waldorf, MD 20601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 8/10/01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ William B Glenn
22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 10 2001
32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27398

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY GENE CAREY

2. Date of Death (Month, Day, Year): August 11 2001

3. Time of Death: 1550

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 213-22-9932

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 18, 1929

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: PITTSVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 34599 PITTS AVE.

10f. Zip Code: 21850

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: PETROLEUM COMPANY

17. Father's Name (First, Middle, Last): WALTER CAREY

18. Mother's Name (First, Middle, Maiden Surname): WILLA TRUITT

19a. Informant's Name/Relationship (Type, Print): MITCHELL CAREY - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5379 WASTEGATE RD. PARSONSBURG, MD 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PITTSVILLE CEMETERY

Date: 8/16/01

20c. Location - City or Town, State: PITTSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Melissa Kay Henry

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASCAD

Due to (or as a consequence of):

b. Congestive Heart Failure.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Renal Failure 24hrs

Due to (or as a consequence of):

d. Pneumonia 48 hrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0054127

29d. Date signed (Month, Day, Year): 8/11/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alon Davis 3 Bistate Blvd Delmar MD 21875

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

213-22-9932

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Harry Carey

6/1/VA

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27399

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary F. Crawford

2. Data of Death: Month August Dey 16 Yaer 2001

3. Tima of Death: 9:36PM

4a Facility Nama (If not institution, giva street and number): Quail Run

4b. City, Town, or Location of Death: Severna Park

4c. County of Deeth: Anne Arundel

**Funeral Director**

5. Social Security Number: 048 16 9465

6. Sex: 1☐ M 2☒F

7. Aga (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Dec 30, 1902

9. Birthplace (State or Foraign Country): Vermont

Usual Rasidence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yas 2☒ No

10a. Street and Number: 118 Arundel Beach Drive

10f. Zip Coda: 21146

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Year or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: white

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Policy Writer

16b. Kind of Business/Industry: Insurance

17. Fathar's Name (First, Middle, Last): William Fisher

18. Mother's Nema (First, Middla, Maiden Surnama): Katherine Hennebery

19a. Informent's Name/Ralationship (Type, Print): Kay Cook/Daughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 7934 Helmart Drive Laurel, Maryland 20723

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stete 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemafary, cramafory or othar placa): Metro Crematory

Data: 8-17-2001

20c. Location - City or Town, State: Catonsville, MD

21. Signelure of Funeral Service Licensee: ▶ Shana a Collins with power M01044

22. Neme and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter tha disaasa, or complications that ceusad tha death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or haert failure. List only ona ceusa on aach line.

Approximata Intarval Batwaen Onset and Death

Immadiata Causa (Final disaasa or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — >2 years

Dua to (or as a consaquance of):

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consaquance of):

c. Dua to (or as a consaquance of):

d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa rafarrad to madical examinar? 1☐ Yes 2☑ No

26. Placa of Daath (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidance 6☑ Other (Specify) Assisted Living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ John F. Koone, M.D.

29c. License number: D52728

29d. Data signed (Month, Day, Year): August 17, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): John F. Koone, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001

32. Registrar's Signature: ▶ Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

(8)

CJC

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27400

CONDE, MARGARITA

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margarita C. Conde

2. Date of Death: Month AUGUST Day 18 Year 2001

3. Time of Death: 11-30 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 581 34 5170

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 25, 1931

9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: N/A

10b. County: N/A

10c. City, Town or Location: San Juan

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1942 Ugalde St.

10f. Zip Code: 00926-6329

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc. Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jose Casanova

18. Mother's Name (First, Middle, Maiden Surname): Margarita Perez

19a. Informant's Name/Relationship (Type, Print): Isidro Conde/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7814 Crossbay Drive Severn, MD 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Crematory | Date: 8-19-2001

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Shawn a Collins-Witzke M01044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. SEPSIS — 7 DAYS

Due to (or as a consequence of): METASTATIC CARCINOMA OF BREAST — 3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D 46962

29d. Date signed (Month, Day, Year): AUGUST 18, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.

**State Registrar**

31. Date filed (Month, Day, Year): AUG 20 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

2001 3410

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27401

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Michael | | Callaghan | 08 | 18 | 2001 | 6:50 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical System | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| N/A | 1 M 2 F | Yrs. | | | 17 | | 08/17/01 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Laurel | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13101 Imperial Court | 20708 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| N/A | N/A | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Francis Michael Callaghan | Michelle McCarty |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Francis Michael Callaghan/Father | 13101 Imperial Court, Laurel, MD 20708 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Ivy Hill Cemetery | 8/23/2001 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Janice Myers M01103 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Severe Pulmonary Hypoplasia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Prolonged Premature Rupture of Membranes

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | 23d. Date of delivery Month | Day | Year |
|---|---|---|---|---|
| | | 08 | 17 | 2001 |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown | |
|---|---|
| 24a. Was an autopsy performed? 1 Yes 2 X No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |

| 25. Was case referred to medical examiner? 1 Yes 2 X No | 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Adora Wonodi, MD | AU4176455013199 | 08/18/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adora Wonodi, Dept. of Pediatrics, University of Maryland Medical System, 22 S. Greene Street, Baltimore, MD, 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(1) dod

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27402

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| GRACE A. CRAVARITIS | August 22 2001 | 6:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Lorien Nursing Home | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 109 10 9665 | 1☐M 2☒F | 83 Yrs. | | | Jan 12, 1918 | New York |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Columbia | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5367 Tarkington Place | 21044 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Teacher/Administrator | Education |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Vincent Ferara | Anne Scaccia |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George Cravaritis/Son | 5367 Tarkington Place Columbia, MD 21044 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Metro Crematory | 8 23-2001 | Catonsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Dena Collins-Witzke MD1044 | Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrythmia death | minutes |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. General Cardiac Aterioscerosis | years |
| Due to (or as a consequence of): | | |
| | c. Systemic Aterioscerosis | |
| Due to (or as a consequence of): | | |
| | d. | |

| If FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension, Rectal Polyps

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ William Kordon MD | D06588 | Aug 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kordon 4801 Dorsey Hall Drive Ellicott City, MD 21042

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 28 2001 | ▶ Geneva G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

10 ded

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27403

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM ALFRED DA ROJA, JR.

2. Data of Death: Month August Day 13 Yaer 2001

3. Time of Death: 2300

4a. Facility Name (If not institution, give street and number): 5154 Francis Scott Key Highway

4b. City, Town, or Location of Death: Taneytown

4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 089-20-7958

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 4, 1927

9. Birthplece (State or Foreign Country): New Jersey

Usuel Residenca of Decedent

10a. Stete: Maryland

10b. County: Carroll County

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5154 Francis Scott Key Highway

10f. Zip Code: 21787

10g. Citizen of What Country? United States

11. Meritel Stafus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1946-1950

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, afc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): engineer

16b. Kind of Businass/Industry: telecommunications

17. Fethar's Neme (First, Middle, Last): William A. Da Roja, Sr.

18. Mother's Name (First, Middle, Maiden Surnama): Estelle Mason

19a. Informant's Name/Relationship (Type, Print): Joan Lois Da Roja / wife

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5154 Francis Scott Key Hwy. Taneytown, MD 21787

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremefion 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cematary, crematory or other place): St. Joseph's Cemetery

Dete: Aug.16 2001

20c. Location - City or Town, State: Taneytown, Maryland

21. Signature of Funeral Service Licensee: Alan C. Powers M01072

22. Name end Address of Facility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Death

Immadiata Cause (Final disease or condition resulting in deeth)

e. PROGRESSIVE SUPRANUCLEAR PALSY

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streaf, fectory, offica buiiding, etc. (Specify)

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete end place, and due to the ceuse(s) and menner as stated. 2 [ ] Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Wasim Fakhar

29c. Licensa number: D0054580

29d. Data signed (Month, Day, Year): 08/14/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Wasim Fakhar, M.D. 49 Frederick Street Taneytown, Maryland 21787

**State Registrar**

31. Dete filed (Month, Day, Year): AUG 15 2001

32. Registrar's Signeture: Geneva B Hooks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 25+IVA

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27404

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| August S. DeLuca, Sr. | August 12, 2001 | 9:30 a.m |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 8497 Mast Ct. | Pasadena | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-01-5592 | 1 [X] M 2 [ ] F | 89 Yrs. | | | July 2, 1912 | Richmond, Va. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Anne Arundel | Pasadena | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8497 Mast Ct. | 21122 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7 | | Barber | Hair Care |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Unknown | Unknown |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Susan E. Bowers - daughter | 8497 Mast Ct. Pasadena, Md. 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Druid Ridge Cemetery | Aug. 16, 2001 | Pikesville, Md. |

21. Signature of Funeral Service Licensee: Justin R. Dubrow

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Ischemic Cardiomyopathy | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Coronary Artery Disease | 20 years |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency, Prostate Cancer, History of Colon Cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [✓] No | 1 [ ] Yes 2 [✓] No |

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| John F. Boone, MD | D52728 | August 13, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Boone, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 15 2001 | Geneva B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27405

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William J. Day JR
2. Date of Death Month Day Year: 8-10-01
3. Time of Death: 8:30 A.M.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-16-7168
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 26708 Ridge Road
10f. Zip Code: 20872
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fingerprint Specialist
16b. Kind of Business/Industry: F.B.I.
17. Father's Name (First, Middle, Last): William Jackson Day, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Sallye Jane King
19a. Informant's Name/Relationship (Type, Print): Barbara J. Day - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26708 Ridge Road, Damascus, Maryland 20872
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Damascus Methodist Cemetery
Date: 8/13/01
20c. Location - City or Town, State: Damascus, Maryland
21. Signature of Funeral Service Licensee: Grant L. Williams
22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Acute Myelogenous Leukemia — Due to (or as a consequence of): — Two Years

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Othar (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar es steted. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha time, date and piece, and due to tha ceusa(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D33646
29d. Date signed (Month, Day, Year): August 10, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kenneth M. Wilson MD (8111 Price Philip Dr. Olney, MD 20832)

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: Barbara A Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27406

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES LEE DAVIS

2. Date of Death Month: AUG Day: 14 Year: 2001

3. Time of Death: 12:50 A

4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

**Funeral Director**

5. Social Security Number: 579-42-6279

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 16, 1932

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 29697 Dogwood Circle

10f. Zip Code: 20659

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Engineer

16b. Kind of Business/Industry: Federal Govt.

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Evelyn Sampogna

19a. Informant's Name/Relationship (Type, Print): Evelyn Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29697 Dogwood Circle, Mechanicsville, MD 20659

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Elmwood Cemetery

Date: 8-18-01

20c. Location - City or Town, State: Wayne, WV

21. Signature of Funeral Service Licensee: David C. Echols

M00945

22. Name and Address of Facility: BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. 20622

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease — yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Renal Insufficiency
Congestive Heart Failure
Neck Cancer

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D19431

29d. Date signed (Month, Day, Year): 8/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank W. Ryan MD 11701 Livingston Rd #203 Ft. Washington MD 20744

**State Registrar**

31. Date filed (Month, Day, Year): AUG 16 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

James L. Davis

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27407

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: RUSSELL DAVIS
2. Date of Death (Month, Day, Year): August 14, 2001
3. Time of Death: 3:09 AM
4a. Facility Name *(If not institution, give street and number)*: 8211 Ball Road
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 214-20-7620
6. Sex: 1 ☐ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 30, 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8211 Ball Road
10f. Zip Code: 21704
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner & Operator
16b. Kind of Business/Industry: Inn

17. Father's Name *(First, Middle, Last)*: Raymond J. Davis
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice M. Reed

19a. Informant's Name/Relationship *(Type, Print)*: Jeff Davis (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8301 Ball Road, Frederick, Maryland 21704

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery — Date: 8/16/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory arrest — 5 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Advanced carcinoma of the lung

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven L. Fish MD
29c. License number: DC MD 8510
29d. Date signed *(Month, Day, Year)*: Aug 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven L. Fish M.D 50 Irving Street, N.W., Washington, DC 20422

**State Registrar**

31. Date filed *(Month, Day, Year)*: ~~8/14~~ AUG 15 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended item#2per MD FCHD,KS 8/16/01 **Certificate of Death**

Reg. No. 2001 27408

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anna Mary Eppley

2. Date of Death Month: ~~August 14, 2001~~ Day / Year: August 13, 2001 — Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 214-10-2195

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6146 Fulmer Road

10f. Zip Code: 21703

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): payroll clerk

16b. Kind of Business/Industry: utility provider

17. Father's Name (First, Middle, Last): Lewis Howard Renn, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Bessie May Stimmel

19a. Informant's Name/Relationship (Type, Print): Betty Shaw, sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6146 Fulmer Road, Frederick, MD 21703

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gardens — Date: 8/16/2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger

22. Name and Address of Facility: Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Ischemia — hours.

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Dua to (or as a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A-Z. HEGAZI MD

29c. License number: D44164

29d. Date signed (Month, Day, Year): 8-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.Z. Hegazi MD 801 Tollhouse Ave, F Frederick MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27409

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Alfred Fouche
2. Data of Death Month Day Year: August 12, 2001
3. Time of Death: 3:45 P.M.

4a. Facility Name *(If not institution, give street and number)*: Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 214-34-7532
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Nov. 9, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 1100 Peach Orchard Lane, Apt. 101
10f. Zip Coda: 21716
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Custodian
16b. Kind of Business/Industry: Public School System

17. Fathar's Nama *(First, Middla, Last)*: Roy L. Fouche
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Vallie Runkles

19a. Informant's Name/Ralationship *(Type, Print)*: Arthur S. Fouche/Brother
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: P. O. Box 87, Rohrersville, MD 21779

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory, or other place)*: Prospect Cemetery — Data: Aug. 16, 2001
20c. Location - City or Town, Stata: Mt. Airy, Maryland

21. Signature of Funaral Service Licensee: Richard C. L. Basford #00021
22. Nama and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

**Physician /Medical Examiner**

23a. Part I. Entar tha diseasa, or complications, that caused tha daath. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death):
a. Congestive Heart Failure — 3 W/S
Due to (or as e consequance of):
b.
Dua to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Daath *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [X] Nursing Home 5 [ ] Rasidance 6 [ ] Othar *(Spacify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurrad at tha time, data and placa, and dua to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and due to tha ceuse(s) and mannar stated.

29b. Signature and title of certifier: Robert L. Kaufmann
29c. Licansa number: D-13971
29d. Data signad *(Month, Day, Yaar)*: 8/14/01

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: AUG 15 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27410

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gracie Mae Fultz
2. Date of Death (Month, Day, Year): August 13, 2001
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): 3851 Prices Distillery Road
4b. City, Town, or Location of Death: Ijamsville
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-32-6958
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 15, 1919
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Ijamsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3851 Prices Distillery Road
10f. Zip Code: 21754
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Lewis
18. Mother's Neme (First, Middle, Maiden Surname): Nancy Morgan

19a. Informent's Name/Relationship (Type, Print): Mrs. Nancey Oakes, Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3851 Prices Distillery Rd., Ijamsville, Md. 21754

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, Aug. 18, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00255
22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): a. STROKE — 2 wks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D47611
29d. Date signed (Month, Day, Year): August 13, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WAGAVEKAR MD 1475 TANEY AVE #204 FREDERICK MD 21702

**State Registrar**

31. Dete filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27411

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Carvel Ogden | Garner | | Aug 7 2001 | 2:40 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3675 Spring Lane | Indian Head | Charles |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 22 0412 | 1 [X] M 2 [ ] F | 71 Yrs. | | | Oct 30 1929 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Charles | Indian Head | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3675 Spring Lane | 20640 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Ret | 1 [ ] Yes 2 [X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | maintance chief | USAF Ret |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard Ogden Garner | Helen A. Woodburn |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard Garner- son | 1510 Highland Dr. Silver Spring MD 20910 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Solomons Cemetery | Aug 10 2001 | Solomons Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ B Rausch | Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 2067 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Metastatic Adenocarcinoma of the primary to the liver and bone | 2 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**To the Hospital or Attending Physician:** The law requires that this death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

| 29a. Certifier (Check only one) | |
|---|---|
| 1 [X] | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. |
| 2 [ ] | **Medicel Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | 31730 | 8/8/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kai-Yin Yeung, MD 8926 Woodyard Road #201 Clinton, MD 20735

| State Registrar | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|---|
| | AUG 0 9 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27412

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Marcelyn B. Gouldman | August 25, 2001 | 8:00 aM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Holy Cross Hospital | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 186-14-3077 | 1☐M 2☒F | 78 Yrs. | | | Nov 06, 1922 | Pennsylvania |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George | Laurel | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9010 Briarcroft Lane #226 | 20708 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Administrative Assistant | United States Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Carmen Baldassare | Mary Divinge |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jon Gouldman /son | 2112 Arrington Road, Marriottsville, MD 21104 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Crestlawn Mem Garden | Aug 28,2001 | Marriottsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00160 | Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finet disease or condition resulting in death) | a. Metastatic lung cancer | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Sepsis | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as e consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Keith E Damsker, MD | D0057019 | August 25, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Keith Damsker, MD 2309 Shorefield Road, Wheaton, Maryland 20902

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 27 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

Caf

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27413

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Betty Frances Gleockler

2. Date of Death: Month August, Day 13, Year 2001

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): 209 S. Main Street

4b. City, Town, or Location of Death: Greensboro

4c. County of Death: Caroline

**Funeral Director**

5. Social Security Number: 143-22-2992

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): July 30, 1928

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Caroline | 10c. City, Town or Location: Greensboro | 10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 209 S. Main Street | 10f. Zip Code: 21639 | 10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Charles Flowers

18. Mother's Name (First, Middle, Maiden Surname): Clara Plack

19a. Informant's Name/Relationship (Type, Print): Ken Gleockler son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 S Main Street Greensboro, Maryland 21639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery

Date: August 17,2001

20c. Location - City or Town, State: Greensboro,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home PA
PO Box 160 Greensboro, Maryland 21639

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ventricular arrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D51639

29d. Date signed (Month, Day, Year): 8-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen Moffett MD 609 Daffin Lane Denton, Maryland 21629

**State Registrar**

31. Date filed (Month, Day, Year): AUG 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27414

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Harold J. Gallion | August 19 2001 | 0600 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Howard County General Hospital | Columbia | Howard |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213 10 7515 | 1☒ M 2☐ F | 93 Yrs. | | | Feb 13, 1908 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Howard | Ellicott City | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3342 Coventry Court Drive | 21042 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Fire Fighter | City Goverment |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph Anthony Gallion | Mamie Klein |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara J. Facto/Daughter | 3342 Coventry Court Drive Ellicott City, MD 21042 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge Cemetery | 8-22-2001 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Shawn A Collins-Witzke M01044 | Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 |

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Septic Shock | 1 day |
| Due to (or as a consequence of): b. | Urosepsis | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c. | Pneumonia | 1 day |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ C Schenk MD | D33627 | August 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carmen Salvaterra, M.D. 10724 Little Patuxent Parkway Columbia, MD 21044

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15 dod

01-4751-027
B..KS
JESSE V. GARAMI

AMENDED 102901:ITEM#23aline b per ME G800 ss
UNPENDED 100901:ITEMS#23a,27 per ME G800 SS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27415

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jesse Vaeth Garami
2. Date of Death: Month AUG. Day 17, Year 2001
3. Time of Death: 1950 PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 213 17 0327
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 22 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 28, 1978
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4345 Wild Filly Court
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1997-99
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Franz Philip Garami
18. Mother's Name (First, Middle, Maiden Surname): Carol Kirwan

19a. Informant's Name/Relationship (Type, Print): Carol Schwartz/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4345 Wild Filly Court Ellicott City, MD 21042

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): All County Crematory — Date: 8-19-2001
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Shenna Collins MO1044
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
b. CARDIOMYOPATHY OF UNCERTAIN ETIOLOGY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. [illegible]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUG. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 2 0 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27416

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): J. Howard Hixson, Jr.

2. Date of Death (Month, Day, Year): August 15, 2001

3. Time of Death: 6:00AM

4a. Facility Name (If not institution, give street and number): 12504 Neale Sound Drive

4b. City, Town, or Location of Death: Cobb Island

4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 578-18-3241

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): June 27, 1917

9. Birthplace (State or Foreign Country): DC Washington

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Cobb Island

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12504 Neale Sound Drive

10f. Zip Code: 20625

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Head of Fire Alarms

16b. Kind of Business/Industry: Federal Govt.

17. Father's Name (First, Middle, Last): J. Howard Hixson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Grace Turner Hixson

19a. Informant's Name/Relationship (Type, Print): J. Howard Hixson, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 193 Valley Lee, MD. 20692

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 8/20/01 | 20c. Location - City or Town, State: Brentwood, MD.

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Failure — wk.

Due to (or as a consequence of):
b. Cardiomyopathy — yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery DZ — yrs.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jas. Jarboe M.D.

29c. License number: D 06419

29d. Date signed (Month, Day, Year): 8-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Jarboe, M.D. P.O. Box 1759 Hollywood, MD. 20636

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27417

MK Hood

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Edwin Grant Hood | 2. Date of Death (Month, Day, Year): Aug 9 2001 | 3. Time of Death: 7:00 AM | |
| 4a. Facility Name (If not institution, give street and number): Towson-Dulaney Health Care Center | 4b. City, Town, or Location of Death: Towson | 4c. County of Death: Baltimore | |
| 5. Social Security Number: 215-07-9518 | 6. Sex: 1☒M 2☐F | 7. Age (In yrs. last birthday): 92 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.) | 8. Date of Birth (Month, Day, Year): Jan 10, 1909 |
| 9. Birthplace (State or Foreign Country): NJ | | | |

Usual Residence of Decedent

| | | | |
|---|---|---|---|
| 10a. State: Md | 10b. County: Baltimore | 10c. City, Town or Location: Towson | 10d. Inside City Limits: 1☐Yes 2☒No |
| 10e. Street and Number: 111 West Road | 10f. Zip Code: 21204 | 10g. Citizen of What Country? USA | |
| 11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yes 2☐No If Yes, Give Year or Dates: Navy WWII | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐Yes 2☒No Specify: | 14. Race - Amarican Indian, Black, White, etc. Specify: white |
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; Collega (1-4or 5+): | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): engineer | 16b. Kind of Business/Industry: Glenn L Martin Co. | |
| 17. Father's Nama (First, Middla, Last): John Edwin Hood | 18. Mother's Nama (First, Middle, Maiden Sumame): Maude O Grant | | |
| 19a. Informant's Name/Relationship (Type, Print): Maudie Hood Dusome (sister) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 4600 Sykesville Rd., #109, Finksburg, Md 21048 | | |
| 20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify) | 20b. Place of Disposition (Name of cemetery, cremetory or other piece): All County Cremation | Data: 8-11-01 | 20c. Location - City or Town, State: Sykesville, Md |
| 21. Signature of Funaral Service Licensee: ▶ Brian L. Haight | 22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 | | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Physician /Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

WJL 3+1VA

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on aach line.

| | | Approximata Intarval Batween Onsat and Death |
|---|---|---|
| Immediata Causa (Final disaasa or condition resulting in death) a. | Cerebral Vascular Accident | 5 years |
| Due to (or as a consequance of): b. | Dementia | 5 years |
| Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequance of): c. | | |
| Due to (or as a consequenca of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐Yas 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy parformed? 1☐Yas 2☑No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐Yas 2☑No

25. Was case referred to medical examinar? 1☐Yas 2☑No

26. Place of Death (Check only ona): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Homa 5☐Rasidance 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yas 2☐No | 28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to tha causa(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licansa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Attending Physician | D53642 | Aug. 9 2001 |

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): KAO Med 3007 E. Northern Parkway Baltimore MARYLAND 21214

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | ▶ Penny D Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27418

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ruth Irene Hanigan

2. Date of Death Month Day Year: August 11, 2001

3. Time of Death: 11:50pm

4a Facility Name *(If not institution, give street and number)*: Continuum Care

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 220-20-2794

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 18, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 31 Shamrock Circle

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 3 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress/Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Earl Burdette

18. Mother's Name *(First, Middle, Maiden Surname)*: Beulah Haney

19a. Informant's Name/Relationship *(Type, Print)*: Mr. J. Patrick Hanigan (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 31 Shamrock Circle Westmintser, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Lake View Memorial Park

Data: 8/15/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville ,MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in daath)

a. Atherosclerotic Coronary Vascular Disease — 10yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other signiflcant conditlona** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert L. Moss, MD

29c. License number: 032882

29d. Date signed *(Month, Day, Year)*: 8/14/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert L. Moss 114 Business Center Dr. Reisterstown, MD 21136

**State Registrar**

31. Data filed *(Month, Day, Year)*: AUG 15 2001

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WJL 3

01-4651-019
B.K.S
RHONDA LYNN HARRISON

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMENDED 011602:ITEMS#23aptI-a,ptII per ME G803 ss

Reg. No. 2001 27419

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rhonda Lynn Harrison
2. Date of Death Month / Day / Year: AUG. 13, 2001
3. Time of Death: 0735 AM
4a. Facility Name *(If not institution, give street and number)*: 601 GOVERNORS AVENUE
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

**Funeral Director**

5. Social Security Number: 212-06-7368
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 31 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 13, 1970
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 503 Governors Avenue
10f. Zip Code: 21613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: dispatcher
16b. Kind of Business/Industry: Sheriff's office

17. Father's Name *(First, Middle, Last)*: Joseph Olin Harrison III
18. Mother's Name *(First, Middle, Maiden Surname)*: Linda Morris

19a. Informant's Name/Relationship *(Type, Print)*: Linda Harrison - mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 601 Governors Ave., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dorchester Memorial Park
Date: 8/16
20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA COMPLICATING SEIZURE DISORDER
Cerebral hemorrhage
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MORBID OBESITY
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], M.D.
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: AUG. 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27420

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: SUSAN REVELLE HOWARD
2. Date of Death — Month: August; Day: 10; Year: 2001
3. Time of Death: 0537
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 212-56-2080
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 25, 1949
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Crisfield
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 3223 Tom Coulbourne Road
10f. Zip Code: 21817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Paintbrush Manufacture

17. Father's Name *(First, Middle, Last)*: G. Bryce Revelle
18. Mother's Name *(First, Middle, Maiden Surname)*: Betty J. Hitt

19a. Informant's Name/Relationship *(Type, Print)*: (Personal Nathan R. Christopher, Jr.Representative)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P. O. Box 491 - Salisbury, MD 21803

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sunnyridge Memorial Park
Date: 8/15/01
20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt
Mary Beth Bradshaw-Pruitt
22. Name and Address of Facility: Bradshaw & Sons Funeral Home
306 W. Main Street - Crisfield, MD 21817

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia Aspiration
Due to (or as a consequence of):
Pancreatitis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c. Coronary Artery Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ischemic colitis, Diabetes Mellitus, Sepsis,
Obesity, Chronic Renal Insuff.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stephen Konlian
29c. License number: D0052039
29d. Date signed *(Month, Day, Year)*: August 10, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN KONLIAN MD 560 RIVERSIDE DR. SALISBURY, MD 21801

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 15 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SUSAN HOWARD 212-56-2080

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27421

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Harry E. Harris
2. Date of Death (Month, Day, Year): August 9 2001
3. Time of Death: 1758 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 226-54-2146
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
6. Date of Birth (Month, Day, Year): March 6, 1944
9. Birthplace (State or Foreign Country): Missouri

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Chincoteague
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5243 Main Street
10f. Zip Code: 23336
10g. Citizen of What Country?: U. S. A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Technician
16b. Kind of Business/Industry: Self
17. Father's Name (First, Middle, Last): Howard Harris
18. Mother's Name (First, Middle, Maiden Surname): Betty Duncan
19a. Informant's Name/Relationship (Type, Print): Amanda H. Taylor Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23449 Mezick Road, Tyaskins, Maryland 21865
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Occohannock Crematory
Date: 8-10-01
20c. Location - City or Town, State: Exmore, Virginia
21. Signature of Funeral Service Licensee: Constance Galyn Corbin Bailey
22. Name and Address of Facility: Salyer Funeral Home Chincoteague, Virginia 23336

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D55658
29d. Date signed (Month, Day, Year): 8/10/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK ARENA, M.D. 100 E CARROLL ST. SALISBURY, MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

AMND TIM/18 PR. F.H. G800 10-4-01 JAB

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27422

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jerome Jones
2. Date of Death: Month 08 Day 13 Year 01
3. Time of Death: 9:45 pm M
4a. Facility Name (If not institution, give street and number): 2134 Snydersburg Road
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 216-34-9721
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 8, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2134 Snydersburg Road
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1953-1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plans Examiner
16b. Kind of Business/Industry: Carroll County

17. Father's Name (First, Middle, Last): Norman Jones
18. Mother's Name (First, Middle, Maiden Surname): THELMA Berta Jones

19a. Informant's Name/Relationship (Type, Print): Michael Jones, son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1844 Deer Park Road, Finksburg, MD 21048

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem Park
Date: 8/17/2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Steven R Eline MD0723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Dissecting Abdominal Aortic Aneurysm — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Norman Goldstein
29c. License number: D26385
29d. Date signed (Month, Day, Year): 08/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Norman Goldstein. 218 Washington Heights Medical Ctr. Westminster MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: Jenna D Sparks

WJL 10/1/VA

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27423

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Alphonse Maxmillian Kostek

2. Date of Death Month / Day / Year: August 9 2001

3. Time of Death: 10:45PM

4a. Facility Name *(If not institution, give street and number)*: 4755 Williamsburg Road

4b. City, Town, or Location of Death: Hurlock

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 212-07-1673

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 8,1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4755 Williamsburg Road

10f. Zip Code: 21643

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Welder

16b. Kind of Business/Industry: Government Research Laboratory

17. Father's Name *(First, Middle, Last)*: Frank J. Kostek

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Vicen

19a. Informant's Name/Relationship *(Type, Print)*: W. Jane Kellenbenz/Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P. O. Box 839, Hurlock, Maryland 21643

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Park

Date: 8/14/01

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, Maryland21631

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Guillain Barré Syndrome — 5 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D50804

29d. Date signed *(Month, Day, Year)*: 8-10-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Malkus, MD 408 Byrn Street Cambridge, MD 21613

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 14 2001

32. Registrar's Signature: Virginia G. Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27424

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): REBECCA P KIRKPATRICK
2. Date of Death (Month, Day, Year): August 14, 2001
3. Time of Death: 6:49 P.M
4a. Facility Name (If not institution, give street and number): 1040 West Court
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 578-07-5876
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 16, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1040 West Court
10f. Zip Code: 20707
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookeeper
18b. Kind of Business/Industry: Advertising Agency

17. Father's Name (First, Middle, Last): Frank Perry
18. Mother's Name (First, Middle, Maiden Surname): Carolyn Murdock

19a. Informant's Name/Relationship (Type, Print): Paul Dale Kirkpatrick/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1040 West Court Laurel, MD 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Bayview Crematory, Inc
Date: August 15 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature] MO0969
22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart Failure — Days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Atrial Fibrillation — Years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D 53411
29d. Date signed (Month, Day, Year): August 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jagdish Shesardi, M.D. 3060 Mitchellville Rd. Bowie, MD 20716

**State Registrar**

31. Date filed (Month, Day, Year): AUG 20 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 27425

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Annetta Dorothy Kueker | August 19 2001 | 1:35 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care Nursing Home | Silver Spring | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 471-22-6094 | 1☐ M 2☒ F | 76 Yrs. | | | Nov. 14 1924 | North Dakota |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Montgomery | Silver Spring | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2501 Musgrove Road | 20904 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | Ø | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Roch Brousseau | Dorothy Beveridge |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| David W. Kueker/Son | 7005 Fitzpatrick Drive, Laurel, MD 20707 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metropolitan Crem. | Aug. 21 2001 | ALEXANDRIA, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00160 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Aspiration Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D43260 | August 21, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenny Y. Moy 13952 Baltimore Avenue, Laurel, MD 20707

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | ▶ [signature] G Sparks |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27426

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Alfred Knox
2. Date of Death (Month, Day, Year): August 14, 2001
3. Time of Death: 10:15a M
4a. Facility Name (If not institution, give street and number): 9411 All Saints Road
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 218-20-1895
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 13, 1925
9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9411 All Saints Road
10f. Zip Code: 20723-1705
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1951 – 1952
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Programmer
16b. Kind of Business/Industry: U.S. Govt. (USDA)

17. Father's Name (First, Middle, Last): Charles Webster Knox
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Fatula

19a. Informant's Name/Relationship (Type, Print): Carolyn Knox / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9411 All Saints Road Laurel, Maryland 20707

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery
Date: August 16, 2001
20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: [signature] M00160
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)
a. Congestive Heart Failure — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Dilated Cardiomyopathy — Years
c. Due to (or as a consequence of): Coronary Artery Disease — Years
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hyperlipemia
Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D25422
29d. Date signed (Month, Day, Year): August 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert T. Maggin, MD 13952 Baltimore Avenue, Laurel, MD 20707

**State Registrar**

31. Date filed (Month, Day, Year): AUG 2 1 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

31+1 dcd

DHMH 17 Rev 1/2001

ORIGINAL

01-4628-013
crn
Connie Jean Legore

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27427

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CONNIE JEANNE LEGORE
2. Date of Death: Month August, Day 13, Year 2001
3. Time of Death: 9:10 A.M.

4a. Facility Name (If not institution, give street and number): 937 Old Westminster Pike
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 220-80-8324
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 9/18/1960
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 937 OLD WESTMINSTER PIKE
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): EARL E. CUMMINGS
18. Mother's Name (First, Middle, Maiden Surname): TILLY E. SCHEUERMANN

19a. Informant's Name/Relationship (Type, Print): MICHAEL B. LEGORE -HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157: 937 OLD WESTMINSTER PIKE, WESTMINSTER, MD.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SANDYMOUNT CEMETERY
Date: 8/17/01
20c. Location - City or Town, State: SANDYMOUNT, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HANGING
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene
27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 8/13/01
28b. Time of Injury: 8:25 AM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT HANGED SELF
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): OUTSIDE RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 937 Old WESTMINSTER PIKE WESTMINSTER, MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. T.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack M. Tiny, M.D. 111 Penn Street, Baltimore, Maryland 21201

WJL 8+1

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27428

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Leroy Langley
2. Date of Death (Month Day Year): Aug 12 2001
3. Time of Death: 655 AM
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 218 03 7077
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 27 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Solomons
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 221 Langley Lane
10f. Zip Code: 20688
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): master carver
16b. Kind of Business/Industry: Calvert Marine Museu Artisan

17. Father's Name (First, Middle, Last): James F. Langley
18. Mother's Name (First, Middle, Maiden Surname): Sophia Morrison

19a. Informant's Name/Relationship (Type, Print): Margaret L. Langley- wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 84 Solomons MD 20688

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Solomons Cemetery | Date: Aug 12, 2001
20c. Location - City or Town, State: Solomons Maryland

21. Signature of Funeral Service Licensee: BRausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 2067

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | VENTRICULAR TACHYCARDIA | 8 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): b. | ACUTE MYOCARDIAL INFARCTION | 8 DAYS |
| Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Peter Wisniewski MD
29c. License number: D40370
29d. Date signed (Month, Day, Year): 8/12/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Wisniewski, M.D. 110 Hospital Rd. Suite 310 Prince Frederick MD 20678

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27429

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LORRAINE C. LANDON

2. Date of Death Month: August Day: 9, Year: 2001

3. Time of Death: 1:25 PM

4a. Facility Name *(If not institution, give street and number)*: Alice Byrd Tawes Nursing Home

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

**Funeral Director**

5. Social Security Number: 215-05-8867

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 1, 1909

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5150 Old Auger Road

10f. Zip Code: 21817

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Garment Manufacturer

17. Father's Name *(First, Middle, Last)*: Asa Crockett

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Parks

19a. Informant's Name/Relationship *(Type, Print)*: Helen Jane Landon (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5150 Old Auger Road - P.O. Box 507 - Crisfield, MD 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunnyridge Memorial Park

Date: 8/12/01

20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt

Mary Beth Bradshaw-Pruitt

22. Name and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. COPD.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 48098

29d. Date signed *(Month, Day, Year)*: AUGUST 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 15 2001

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27430

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sara Regina Lusk

2. Date of Death: Month August Day 19 Year 2001

3. Time of Death: 7:10 A M

4a. Facility Name (If not institution, give street and number): 7002 Fitzpatrick Drive

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 213-22-3754

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 31, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 7002 Fitzpatrick Drive

10f. Zip Code: 20707

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Representative

18b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Raymond Francis Small

18. Mother's Name (First, Middle, Maiden Surname): Hilda Ishanski

19a. Informant's Name/Relationship (Type, Print): Randolph Lusk /spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7002 Fitzpatrick Drive, Laurel, Maryland 20707

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: Aug 21,01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Laurie Donaldson M00160

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colon cancer — 10 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas Koutrelakos MD

29c. License number: D38509

29d. Date signed (Month, Day, Year): Aug 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas W. Koutrelakos, M.D. 11065 Little Patuxent Parkway, Columbia, MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): AUG 2 1 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 ded

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27431

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Larrimore

2. Date of Death: Month August Day 7 Year 2001

3. Time of Death: 0405 M

4a. Facility Name (If not institution, give street and number): The Kent and Queen Anne"s Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

**Funeral Director**

5. Social Security Number: 215-44-6129

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 9,1911

9. Birthplace (State or Foreign Country): MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE

10c. City, Town or Location: CENTREVILLE

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 402 ISLAND CREEK ROAD

10f. Zip Code: 21617

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): EDWARD MIDDLETON

18. Mother's Name (First, Middle, Maiden Surname): WIHELMINA STAATS

19a. Informant's Name/Relationship (Type, Print): DEBBIE TOTH/ GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 ISLAND CREEK ROAD, CENTREVILLE, MD 21617

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): CHESTERFIELD CEMETERY

Date: 8-10-2001

20c. Location - City or Town, State: CENTREVILLE, MD

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 3 MTHS

Due to (or as a consequence of):

b. CHRONIC ATRIAL STROKE — 2 YRS

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the causa of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John C. Seymour MD

29c. License number: D-0013824

29d. Dete signed (Month, Dey, Year): 8.7.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN C. SEYMOUR, M.D., 122 SPEER ROAD, CHESTERTOWN, MD 21620

**State Registrar**

31. Date filed (Month, Dey, Year): AUG 08 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27432

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Marie Masloff
2. Date of Death Month Aug. Day 14, Year 2001
3. Time of Death: 8 A.M.
4a. Facility Name (If not institution, give street and number): Fairhaven Health Care Center
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 220 30 1605
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 12, 1926
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7200 Third Ave.
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Technician
16b. Kind of Business/Industry: N.I.H.

17. Father's Name (First, Middle, Last): John L. Caywood
18. Mother's Name (First, Middle, Maiden Surname): Ethel Wolfe

19a. Informant's Name/Relationship (Type, Print): Herbert S. Masloff, Sr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7200 Third Ave. Sykesville, Md. 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Svc.
Date: 8/15/2001
20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers Dementia — 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
26a. Date of Injury (Month, Day Year)
26b. Time of Injury
26c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
26f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert L. Moss, MD
29c. License number: 032882
29d. Date signed (Month, Day, Year): 8/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Moss 114 Business Center Dr. Reisterstown, Md 21136

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: ▶ Geneva B Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 5

DHMH 16 Rev 6/95

CPM
01-4497-021
RALPH MURTIFF, JR.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27433

UNPENDED 101901: ITEMS 23a, 27 per ME C800 ss

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| RALPH LEWIS MURTIFF, JR. | AUGUST 7, 2001 | 12:29 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 446 WEST SOUTH STREET | FREDERICK | FREDERICK |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-62-2614 | 1☐ M 2☐ F X | 46 Yrs. | | | 6-301955 | pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | Frederick | Frederick | X☐ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 446 West South Street | 21701 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12th | | House Painter | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| Ralph Lewis Murtiff, Sr. | Anna Alice Baughman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Anna Alice Murtiff (Mother) | 5915 Bryan Dr. Frederick, Md. 21703 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) | Smithsburg Crematory | 8-13-01 | Smithsburg, Md. |

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market Street Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Wes en autopsy performed? | 24b. Were autopsy findings available prior to completion of causa of death? |
|---|---|
| 1☑ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| X☒ Yes 2☐ No | Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rural Routa Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. X☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Wayne Mellott | O.C.M.E. | AUGUST 8, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SNYDER or A. KORELITZ 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 14 2001 | Bruce G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 27434

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Evelyn Maschauer

2. Date of Death Month August Day 9, Year 2001

3. Time of Death: 12:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 217-10-0103

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 7, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7407 Willow Road

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Clothing Factory

17. Father's Name *(First, Middle, Last)*: David C. Klipp

18. Mother's Name *(First, Middle, Maiden Surname)*: Teresa C. Korrell

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Reta M. Mathis, sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 260 Gardenia Road, Kissimmee, Fla. 34743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Springs Cemetery, Aug. 13, 2001

20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Stup M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church St., Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cerebrovascular Accident | 3 days |
| Due to (or as a consequence of): b. | Hypertension | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Casper E. Cline III MD

29c. License number: D 16428

29d. Date signed *(Month, Day, Year)*: 8/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Maryland 21701

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 13 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27435

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): NORMA LEE MYERS
2. Date of Death (Month, Day, Year): AUGUST 10, 2001
3. Time of Death: 5:15 P.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 212-30-8979
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.21,1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7401 Willow Rd.
10f. Zip Code: 21702
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Norvell Cullison
18. Mother's Name (First, Middle, Maiden Surname): Anna C. Milchling

19a. Informant's Name/Relationship (Type, Print): Jack A. Myers / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7401 Willow Rd./ Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gard.
Date: 08/14/01
20c. Location - City or Town, State: Frederick,Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson
22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Severe Dehydration | 1 week |
| Due to (or as a consequence of): b. | Perforated bowel | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Advanced ovarian Cancer | 2 years |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 41866
29d. Date signed (Month, Day, Year): AUGUST 13,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kanan Hudhud, MD 801 Tollhouse Avenue, F Frederick, MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMENDED ITEM#11 PER FH FCHD,KS 8/15/01

Reg. No. 2001 27436

Physician /Medical Examiner

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| ROLAND L MEYETT | AUGUST 11, 2001 | 3:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick | Frederick |

Funeral Director

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-05-1340 | 1☐M 2☐F X | 87 Yrs. | | | 12-13-1913 | Rhode Island |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Frederick | Frederick | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 123 East 8th Street | 21701 | U.S.A. |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed X 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: X | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5 years | | Mechanical Engineer | Engineering |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Frank L. Meyette | Pattie Jones |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Eleanor W. Meyette (Wife) | 123 East 8th Street Frederick, Md 21701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation X 3☐Removal from State 4☐Donation 5☐Other (Specify) | Smithsburg Crematory | 8-12-01 | Smithsburg, Md. |

21. Signature of Funeral Service Licensee ▶ Robert E. Dailey Jr

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. preumonia | 7 days |
| Due to (or as a consequence of): | b. Myelodysplastic Syndrome | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Wes an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D 48184 | 8/11/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
501 W 7th Street Frederic MD 21701

State Registrar

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| AUG 14 2001 | ▶ Penne B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#7&8per FH FCHD,KS **Certificate of Death** Reg. No. 2001 27437

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Data of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| JOHN | CEDRIC | MILLBERRY | Aug. 13 2001 | 5:20 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 800 MOTTER AVE APT 701 | FREDERICK | FREDERICK |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-18-7546 | 1☑M 2☐F | 78 Yrs. | | | November 22, 1922 | FREDERICK |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | FREDERICK | FREDERICK | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 800 Motter Ave Apt. 701 | 21701 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced | 1☑Yes 2☐No If Yes, Give Year or Dates: WWII | 1☐Yes 2☑No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8TH | | CONCRETE FINISHER | CONSTRUCTION |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Millberry | Ardella Lee |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DON Millberry (Son) | 6754 BRACE COURT FREDERICK MD 21701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | METRO CREMATORY | Aug 21, 2001 | BALT. MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gary L. Rollins | GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FREDERICK MD 21701 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications that ceused tha death. Do not anter the moda of dying, such as cardiac or raspirator arrest, shock, or heart failura. List only one cause on each line.

Approximate Intarval Batwaan Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACSVD — Dua to (or as a consequence of): — years.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d. —

| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcoma of pregnancy | 23d. Date of dalivary Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fatel daath 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

| 23a. Did tobacco use contributa to tha ceusa of daath? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of daath? |
|---|---|---|
| 1☑Yas 2☐No 3☐Probably 4☐Unknown | 1☐Yas 2☑No | 1☐Yas 2☐No |

| 25. Was cese referred to medicat examiner? | 26. Place of Daath (Chack only ona) | |
|---|---|---|
| 1☑Yas 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Othar: 4☐Nursing Homa 5☑Rasidanca 6☐Other (Specify) |

| 27. Manner of Daath | 28a. Date of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascribe how injury occurrad |
|---|---|---|---|---|
| 1☑Naturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yas 2☐No | |

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurrad at the time, data and place, and dua to tha cause(s) and manner as stated.
2☑ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the ceusa(s) and mannar stated.

| 29b. Signature and title of certifier | 29c. Licensa number | 29d. Data signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D35164 | August 16, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew BARRICK, Jr. MD 1080 W. Patrick st Frederick, MD 21703

**State Registrar**

| 31. Date filed (Month, Day, Yaar) | 32. Registrar's Signatura |
|---|---|
| AUG 16 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27438

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HOLTON MERSON | 08 16 01 | 12-05 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| LAUREL REGIONAL HOSPITAL | LAUREL | PRINCE GEORGES, |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-16-2100 | 1☒M 2☐F | 81 Yrs. | | | 03 07 20 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Laurel | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 916 Nichols Drive | 20707 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No 1941-1945 | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | Ø | Salesman | Brick |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Emory Gorman Merson | Amanda Geis |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| J. Gail Bernhard/Daughter | 15209 Alan Drive, Laurel, MD 20707 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Ivy Hill Cemetery | 8/20/2001 | Laurel, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00773 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ACUTE MYOCARDIAL INFARCTION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. CORONARY ARTERY DISEASE. | 5-YEARS. |
| | Due to (or as a consequence of): c. ADENO CARCINOMA LEFT LUNG. | |
| | Due to (or as a consequence of): d. ADENO CARCINOMA COLON. WITH LIVER METASTASIS. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivary Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

VENTRICULAR ARRHYTHMIA.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☒Yes 2☐No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Abdul Nayeem M.D. | D21294 | 08 16 01. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABDUL NAYEEM M.D. 3450 FORT MEADE ROAD #100 LAUREL, MD. 20724

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | Geneva G Sparks |

12+1 ded

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS 10a-f PER FH G 800 10/10/01 JH **Certificate of Death**

Reg. No. 2001 27439

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY KATHERINE MILLER

2. Date of Death Month Day Year: JULY 31, 2001

3. Time of Death: 6:15PM

4a. Facility Name (If not institution, give street and number): 1337 QUEEN ANNE DRIVE

4b. City, Town, or Location of Death: CHESTER

4c. County of Death: QUEEN ANNE'S

**Funeral Director**

5. Social Security Number: 031-07-0572

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 18, 1916

9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: ~~MD~~ AR

10b. County: ~~QUEEN ANNE'S~~ CRAWFORD

10c. City, Town or Location: ~~CHESTER~~ VAN BUREN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: ~~1337 QUEEN ANNE DRIVE~~ 2706 REEVES CIRCLE

10f. Zip Code: ~~21619~~ 72956

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SOCIAL WORKER

16b. Kind of Business/Industry: STATE GOVERNMENT

17. Father's Name (First, Middle, Last): RICHARD JOHN FLANNERY

18. Mother's Name (First, Middle, Maiden Surname): ANNE MALLAY

19a. Informant's Name/Relationship (Type, Print): DORANNE K. DEVEY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1337 QUEEN ANNE DRIVE CHESTER, MD. 21619

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CALVARY CEMETERY

Date: 8/4/2001

20c. Location - City or Town, State: HOT SPRINGS, AR.

21. Signature of Funeral Service Licensee: Chad M. Helfenbein, CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MD. 21619

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Birgitta E. Miller MD

29c. License number: D50152

29d. Date signed (Month, Day, Year): August 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Birgitta E. Miller, MD 8601 Veterans Highway Suite 111 Millersville MD 21108

**State Registrar**

31. Date filed (Month, Day, Year): AUG 01 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27440

LILLIAN V. NUTTER

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lillian Virginia Nutter
2. Date of Death (Month, Day, Year): August 2, 2001
3. Time of Death: 1:40 P M
4a. Facility Name (If not institution, give street and number): Salisbury Rehab & Nursing Center
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 219-07-6954
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-3-1917
9. Birthplace (State or Foreign Country): Md.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Nanticoke
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 2713 Bank Road
10f. Zip Code: 21840
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Wicomico Co. Board of Education

17. Father's Name (First, Middle, Last): Edward Barclay
18. Mother's Name (First, Middle, Maiden Surname): Mary Waters

19a. Informant's Name/Relationship (Type, Print): Robert Nutter Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 161 Nanticoke, Md. 21840

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Mem. Gardens
Date: 8-8-01
20c. Location - City or Town, State: Hebron, Md.

21. Signature of Funeral Service Licensee: Clifton Messick IV Lic#M00416
22. Name and Address of Facility: Messick Funeral Home PO BOX 61 Bivalve,Md. 21814

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Parkinson's Disease — Approximate Interval Between Onset and Death: yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Dementia — yrs.
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-29349
29d. Date signed (Month, Day, Year): 8/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR.,SALISBURY, MD 21804

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3DQ

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27441

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DONALD A PLOCK

2. Date of Death: Month AUG Day 12 Year 01

3. Time of Death: 0138 AM

4a. Facility Name (If not institution, give street and number): Charlotte Hall Veterans Home

4b. City, Town, or Location of Death: Charlotte Hall

4c. County of Death: St Mary's

**Funeral Director**

5. Social Security Number: 212-03-4712

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 6 1932

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: St Mary's

10c. City, Town or Location: Charlotte Hall

10d. Inside City Limits: 1☐ Yes X☐ No

10e. Street and Number: 29449 Charlotte Hall Road

10f. Zip Code: 20622

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1952-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Susan McMillian (PRD)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29449 Charlotte Hall Road Charlotte Hall, MD 20622

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Maryland Veterans Cemetery

Date: 8-17-01

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: [signature] MO0173

22. Name and Address of Facility: Eberwein Funeral Services, 4433 White Pls. Ia. White Pls., MD 20695

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC NON SMALL CELL CARCINOMA (LUNG)

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ANEMIA, HYPERCALCEMIA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE PLEURAL EFFUSION, HYPERTENSION, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D50963

29d. Date signed (Month, Day, Year): 08/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FULTON LUKIAN, MD, CHARLOTTEHALL, MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8/12/01 1:38 AM DONALD PLOCK

IVA

VOID

CERTIFICATE ⌘

01-27442

SEE

CERTIFICATE ⌘

01-20819

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#3 23a perPHYG798 8/7/01 EV **Certificate of Death**

Reg. No. 2001 27443

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beverly Thyeis Poffenberger

2. Date of Death: Month July Day 29 Year 2001

3. Time of Death: 0940 A M

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington Cty

**Funeral Director**

5. Social Security Number: 212-24-6909

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): June 2, 1928

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: XX Yes 2☐No

10e. Street and Number: 223 N. Locust St.

10f. Zip Code: 21740

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married XX 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Millard Lipps

18. Mother's Name (First, Middle, Maiden Sumame): Ethel B. Eversole

19a. Informant's Name/Relationship (Type, Print): Wilford L. Poffenberger/Hus

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 223 N. Locust St., Hagerstown,MD 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. View Cemetery

Date: 8/1/01

20c. Location - City or Town, State: Sharpsburg, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gerald N. Minnich Fun. Hm.,Hagerstown,MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA = HEMORRAGHE

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): ACUTE RESPATORY FAILURE — Cardiopulmonary Arrest — 15 Days

b. Due to (or as a consequence of): EMPHYSEMA — Intracerebral Bleeding

c. Due to (or as a consequence of): COPD

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic Obstructive Lung Disease

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D27898

29d. Date signed (Month, Day, Year): 8/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): AUG 0 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WASH-370

# 23 Item 1

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#24aperVERBALG799 9/2 Certificate of Death

Reg. No. 2001 27444

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| Baker Young Parker | Aug. 9, 2001 | 4:43PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 318 Sansbury Road | Friendship | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-36-7491 | 1☒M 2☐F | 94 Yrs. | | | Jul 28 1907 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Friendship | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 318 Sansbury Road | 20758 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Farming | Own Farm |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Raphael C. E. Parker | Mary Young |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thomas Parker (son) | P.O. Box 187 Loveville, MD 20656 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Mary's Ch. Cem | Aug 13 2001 | Clinton, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Gary J. Goff | Lee Funeral Home Calvert, P<br>Owings, Maryland 20736 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Heart Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Deid Varner MD | D33512 | August 10, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22744

Deidra L. Varner, M.D. 11701 Livingston Rd., #101; Ft. Washington, MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | Jennie B Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 26-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27445

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: RUTH MAE PAULETTE

2. Date of Death (Month, Day, Year): August 12 2001

3. Time of Death: 2:50 pm

4a. Facility Name *(If not institution, give street and number)*: 1838 Whitehaven Rd.

4b. City, Town, or Location of Death: Church Creek

4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 220-28-2052

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 22 1932

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Church Creek

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1838 Whitehaven Rd.

10f. Zip Code: 21622

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: antique dealer

16b. Kind of Business/Industry: retail

17. Father's Name *(First, Middle, Last)*: Edward Elliott

18. Mother's Name *(First, Middle, Maiden Surname)*: Nettie Travers

19a. Informant's Name/Relationship *(Type, Print)*: Ernest Paulette - husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1838 Whitehaven Rd., Church Creek, MD 21622

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dorchester Memorial Park

Date: 8/15

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R. Thomas Jr

22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St. Cambridge MD 21613

**Physician /Medical Examiner**

23a. Part1. Enter the disaasa, or compiications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart teilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Small Cell Cancer of the Lung — several years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicei examiner? 1☐ Yas 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lois A Narr D.O.

29c. License number: H44615

29d. Date signed *(Month, Day, Year)*: 8/13/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Lois A. Narr D.O. 2 Aurora St Cambridge MD 21613

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 14 2001

32. Registrar's Signature: ▶ Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 27446
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Nama *(First, Middle, Last)*: Ruth Elizabeth Rayburn

2. Date of Death — Month: August; Day: 13; Yaar: 2001

3. Tima of Death: 7:30a M

4a. Facility Nama *(If not institution, give street and number)*: Southern Maryland Hospital Center

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 212-20-0894

6. Sex: 1☐M 2☒F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: 09/01/1924

9. Birthplaca *(State or Foraign Country)*: PA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 12140 Ell Lane, Apt. 102

10f. Zip Code: 20602

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Dacedent of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Raca - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Waitress

16b. Kind of Business/Industry: Restaurant

17. Fathar's Nama *(First, Middle, Last)*: Walter Thomas Behe, Sr.

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Esther Irene Winn

19a. Informant's Name/Relationship *(Type, Print)*: Carol J. Wayson / daughter

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 6235 So. MD Blvd., Lothian, MD 20711

20a. Mathod of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Other *(Specify)*

20b. Placa of Disposition *(Name of cematary, crematory or other placa)*: Metropolitan Crematory

Data: 08/17/01

20c. Location - City or Town, Stata: Alexandria, VA

21. Signatura of Funeral Service Licensee: William B [illegible]

22. Nama and Addrass of Facility: Rausch Funeral Home, P.A. Owings, MD 20736

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Entar tha disease, or complications that caused tha death. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tina.

Approximate Intarval Batwaen Onsat and Daath

Immediata Cause (Final disease or condition rasulting in daath)

a. Non-Hodgkin's Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events rasulting in daath) Last

b. Respiratory Failure

Due to (or as a consequence of):

c. Lymphadenopathy

Due to (or as a consequence of):

d. Anemia

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yes, outcoma of pregnancy: 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar *(specify)* _____ 9☐Unknown

23d. Date of dalivary — Month: Day: Yaar:

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

Methicillin-Resistant Staph aureus (MRSA) wound infection

Gastrointestinal Bleeding

23a. Did tobacco use contribute to the cause of death? 1☒Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐Yas 2☐No

25. Was case referrad to medical examiner? 1☐Yes 2☒No

28. Placa of Daath *(Check only ona)* — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Homa 5☐Residance 8☐Othar *(Specify)*

27. Manner of Daath: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and title of certifiar: [illegible] MD

29c. Licensa numbar: D0053219

29d. Data signed *(Month, Day, Yaar)*: 8·14·2001

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print): Zafar A. Ansari, MD, 7E Post Office Rd., Waldorf, MD 20602

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: AUG 15 2001

32. Registrar's Signatura: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 17 Rav 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27447

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John Alton Rushing | August 11, 2001 | 12:28 p M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Calvert Memorial Hospital | Prince Frederick | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577 44 6699 | 1☒ M 2☐ F | 68 Yrs. | | | Feb. 10, 1933 | Wash., DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Calvert | Chesapeake Beach | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4018 13 th Street | 20732 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☒ Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | title agent | real estate |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Alton Leonard Rushing | Catherine Julia Roache |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary C. Rushing (wife) | PO Box 669, Chesapeake Beach, MD 20732 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Metropolitan Crematory | 8-13-01 | Alexandria, VA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| [signature] | Rausch Funeral Home, Owings, MD 20736 |

**Physician /Medical Examiner**

20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. CORONARY ARTERY DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Chronic Obstructive Lung Disease

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D-25435 | 8/11/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Mather, M.D. Prince Frederick Md 20678

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 13 2001 | [signature] G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

12
1 VA

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27448

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUIS CHARLES REANT

2. Date of Death (Month, Day, Year): Aug 15 2001

3. Time of Death: 5:55 am

4a. Facility Name (If not institution, give street and number): Beverly Health Care of Frederick

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 235-24-8656

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 21 1923

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5685 Crabapple Drive

10f. Zip Code: 21703

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942/46 1950/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8+ | College (1-4or 5+): 8+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Internal Auditor

16b. Kind of Business/Industry: Co. Gov't.

17. Father's Name (First, Middle, Last): Louis F. Reant

18. Mother's Name (First, Middle, Maiden Surname): Katherine Caume

19a. Informant's Name/Relationship (Type, Print): Audrey M Reant/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5685 Crabapple Dr. Frederick, MD 21703

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven

Date: 8/17/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Will C Hilt

22. Name and Address of Facility: Hilton Funeral Home, Barnesville, MD 20838

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer with

Due to (or as a consequence of):

b. metastases to liver — 6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, macular degeneration
Thyroid disease,
Prostatic Hyper

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Allen Kelly MD

29c. License number: D54749

29d. Date signed (Month, Day, Year): 8 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 30 North Place, Frederick, MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001

32. Registrar's Signature: ▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27449

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ruby Jane Schultz

2. Date of Death Month Day Year: August 10, 2001

3. Time of Death: 10:15 pm

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing & Rehabilitative Ctr

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 578-46-3194

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 19,1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1923 Hanover Pike

10f. Zip Coda: 21074

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11 / College (1-4or 5+)

16a. Decedent's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Department Store

17. Father'a Neme *(First, Middle, Last)*: John Henry Blocher

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Pearl Shamer

19a. Informent's Neme/Reletionship *(Type, Print)*: M. Virginia Lowe, daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2048 Royal Fern Ct, 321B, Reston, VA 20191

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cematary, cremetory or othar place)*: Carroll Cremations

Dete: 8/14 2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven W Eline M00723

22. Nama and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter tha disaasa, or complications that causad the deeth. Do not enter the mode of dying, such es cardiec or raspiratory arrest, shock, or heert failure. List only ona ceuse on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

e. ASCVD — 30yr

Due to (or as a consequence of):

b. advanced age — 93yr

Sequentially list conditions, if any, leading to immediete cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last

Due to (or es a consequence of):

c.

Due to (or as e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of tnjury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end mannar stated.

29b. Signeture end title of certifier: John Middleton

29c. License number: D25443

29d. Data signed *(Month, Day, Year)*: 8-12-01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster, Md 21157

**State Registrar**

31. Dete filed *(Month, Dey, Yaar)*: AUG 14 2001

32. Registar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

WSC 6

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27450

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lena Mae Stapleton
2. Date of Death (Month, Day, Year): August 8, 2001
3. Time of Death: 3:00pm M
4a. Facility Name (If not institution, give street and number): 1424 Buckhorn Road
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 408-38-2085
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 26, 1925
9. Birthplace (State or Foreign Country): Tennessee

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1424 Buckhorn Road
10f. Zip Code: 21784
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Licensed Practical Nurse
18b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): A.P. Hurd
18. Mother's Name (First, Middle, Maiden Surname): Lena Mae Horton

19a. Informant's Name/Relationship (Type, Print): Mrs. Paulette Naurot (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 176 Laurier Drive Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mem. Park
Date: 8/11/01
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Amyotrophic Lateral Sclerosis — 2yrs

Due to (or as a consequence of):
b. Respiratory failure — 4mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jeffrey D. Rothstein
29c. License number: D0038291
29d. Date Signed (Month, Day, Year): 8/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey D. Rothstein, Johns Hopkins Univ. 600 N. Wolfe St. Balt. MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: ▶ Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 8

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-4646-013

RICHARD SIMPERS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27451

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Franklin Simpers
2. Date of Death (Month, Day, Year): AUGUST 13, 2001
3. Time of Death: 9:10P.M.
4a. Facility Name (If not institution, give street and number): 3611 MILLERS STATION
4b. City, Town, or Location of Death: MANCHESTER
4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 220-16-0865
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 24, 1922
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3611 Millers Station Road
10f. Zip Code: 21102
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): George Folkert Simpers
18. Mother's Name (First, Middle, Maiden Surname): Flora Elizabeth Berwager

19a. Informant's Name/Relationship (Type, Print): Shirley Simpers, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3611 Millers Station Rd, Manchester, MD 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Lutheran Cemetery — Date: 8/17 2001
20c. Location - City or Town, State: Manchester, MD

21. Signature of Funeral Service Licensee: M00723 Steven Wilson
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 8/13/01 FOUND
28b. Time of Injury: 2030 FOUND M
28c. Injury at Work? 1☒ Yes 2☐ No
28d. Describe how injury occurred: FARM TRACTOR OVERTURNED ONTO SUBJECT
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FIELD OF FARM
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3611 MILLERS STATION, MANCHESTER, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. Licensa number: O.C.M.E.
29d. Data signed (Month, Day, Year): AUGUST 14, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27452

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Wynona Lewis Skinner
2. Date of Death (Month, Day, Year): August 12, 2001
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): Heartland of Hyattsville
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: P.G. Co.

**Funeral Director**

5. Social Security Number: 579-56-2093
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10, 1914
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: MD
10b. County: P.G. Co.
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8109 Croom Station Road
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Writer
16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): John A. Lewis
16. Mother's Name (First, Middle, Maiden Surname): Eula Snider

19a. Informant's Name/Relationship (Type, Print): Louise Skinner (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8109 Croom Station Rd., Upper Marlboro, MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Little Oak UMC Cem.
Date: Aug. 17, 2001
20c. Location - City or Town, State: Goshen, AL

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home Calvert, P.A. 20736
8125 Southern Maryland Blvd., Owings, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — Approximate Interval Between Onset and Death: 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure,
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D01852
29d. Date signed (Month, Day, Year): August 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. DeVore, M.D. 4203 Queensbury Rd., Hyattsville, MD 20781

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27453

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| DONALD WILLIAM SEARS | Aug 8, 2001 | 8:30a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Calvert Memorial Hospital | Prince Frederick | Calvert |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-56-8018 | 1 [X] M 2 [ ] F | 48 Yrs. | | | Sept. 12, 1952 | Wash. D.C. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Calvert | Huntingtown | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2415 Smokey Road | 20639 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Roofer | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Herman Donald Sears | Mary Jane Dixon |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Linda Jarboe / sister | 910 Leesburg Ct., Huntingtown, MD 20639 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Southern Memorial Gar. | 08/11/01 | Dunkirk, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Charles F. Bell | Rausch Funeral Home, P.A., Owings, MD 20736 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer — Approximate Interval Between Onset and Death: More than 1 year.

Due to (or as a consequence of):

b. Head and Neck Cancer — More than 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure.
Hypokalemia.
Chronic obstructive lung disease

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown | 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Gyan-C Surana. | D 50653 | 8-8-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN-C SURANA
5851 Deale Churchton Road. Deale MD. 20751

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 10 2001 | ▶ [signature] |

5

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2001 27454

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Inez Agnes Stanley
2. Date of Death: Month August Day 14 Year 2001
3. Time of Death: 3:00 a.m.
4a. Facility Name (If not institution, give street and number): Chesapeake Woods
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 214-07-9999
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 93 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 14, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 525 Glenburn Avenue
10f. Zip Code: 21613
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Line Worker
16b. Kind of Business/Industry: Seafood Industry

17. Father's Name (First, Middle, Last): William Opher
18. Mother's Name (First, Middle, Maiden Surname): Annie Waters

19a. Interment's Name/Relationship (Type, Print): Stella M. Beasley
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1508 Colony Road Oxon Hill, Maryland 20745

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Madison Cemetery
Date: 8/18/2001
20c. Location - City or Town, State: Woolford, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 21613 510 Washington St, Cambridge, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Congestive Heart Failure | 10 years |
| Due to (or as a consequence of): b. | Stasis Dermatitis | 5 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Osteoarthritis | 20 yrs |
| d. | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Immediate attending physician
29c. License number: D15541.
29d. Date signed (Month, Day, Year): 8/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vinodrai Mehta MD 402 Byrn Street Cambridge MD 21613

**State Registrar**

31. Date filed (Month, Day, Year): AUG 16 2001
32. Registrar's Signature: Deanna G. Hooper

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 27455

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Clark Howard Schlossnagle

2. Date of Death — Month: July; Day: 21; Year: 2001

3. Time of Death: 2:20 AM

4a. Facility Name *(If not institution, give street and number)*: Garrett County Memorial Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

**Funeral Director**

5. Social Security Number: 220-10-8525

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: April 12,1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Mt Lake Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 708 I Street

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farming

16b. Kind of Business/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: Howard Schlossnagle

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude Spoerlein

19a. Informant's Name/Relationship *(Type, Print)*: Ethel V Schlossnagle/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 708 I Street Mt Lake Park, MD 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bear Creek Cemetery

Date: 7/24/2001

20c. Location - City or Town, State: Accident, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Newman Funeral Homes, PA PO Box 275 179 Miller St Grantsville, MD 21536

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D15333

29d. Date signed *(Month, Day, Year)*: 8/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 23 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

*Certificate of Death*

Reg. No. 2001 27456

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Anna K. Schmidt | August 17 2001 | 7:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Laurel Regional Hospital | Laurel | Prince George's |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-28-6665 | 1☐M 2☒F | 95 Yrs. | | | June 22 1906 | Switzerland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Laurel | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 408 Greenhill Avenue | 20707 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | Ø | Owner/Operator | Hotel/Restaurant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Gottlieb Kuenzi | Maria Anna Amstruc |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William Walter Schmidt/Son | 7007 Sandy Spring Road, Laurel, MD 20707 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Ivy Hill Cemetery | 8/20/2001 | Laurel, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] M00773 | Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sudden Cardiac Death | Immediately |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Critical Aortic Stenosis | 5 years |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Aortic Dissection, Abdominal Aortic aneurysm, Permanent Pacemaker, Mixed Parotid Tumor, Thyroid Nodule

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] MD | D22755 | August 17, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christine DeLima, MD 7350 Van Dusen Road, #260, Laurel, MD 20707

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 21 2001 | ▶ [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27457

Townsend. Eleanor

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eleanor Arndt Townsend
2. Date of Death (Month, Day, Year): August 9, 2001
3. Time of Death: 5:15am
4a. Facility Name (If not institution, give street and number): The Wesley Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 220-34-5125
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 30, 1902
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3707 Nauset Place
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Herman Arndt
18. Mother's Name (First, Middle, Maiden Surname): Margaret Ruppert

19a. Informant's Name/Relationship (Type, Print): Mr. Miles Dale Townsend (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 E. Maple Street Linthicum, MD 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wards Chapel Cemetery
Date: 8/11/01
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: ▶ Brian A. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. CEREBRO VASCULAR DISEARE
Due to (or as a consequence of):
b. ADVANCED AGE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
pneumonia, ALZheimer's Disease, h/o Cancer of Breast.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ R. Liberto, MD.
29c. License number: D21464
29d. Date signed (Month, Day, Year): 8/10/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 Bank St. Balto, Md 21224

**State Registrar**

31. Date filed (Month, Day, Year): AUG 14 2001
32. Registrar's Signature: ▶ Benna B Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27458

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Myra Lucille Towers

2. Date of Death (Month, Day, Year): August 13 2001

3. Time of Death: 10:00am

4a. Facility Name *(If not institution, give street and number)*: 25387 Goldsboro Road

4b. City, Town, or Location of Death: Henderson

4c. County of Death: Caroline

**Funeral Director**

5. Social Security Number: 215-18-3745

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov.11,1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Henderson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 25387 Goldsboro Road

10f. Zip Code: 21640

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dry Cleaning

16b. Kind of Business/Industry: Laundry

17. Father's Name *(First, Middle, Last)*: Roland Black

18. Mother's Name *(First, Middle, Maiden Surname)*: Cleo Marshall

19a. Informant's Name/Relationship *(Type, Print)*: Sandra L. Holland/Daugh.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25387 Goldsboro Rd.Henderson, MD 21640

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Jr.Order Cemetery

Date: 8/17/01

20c. Location - City or Town, State: Preston, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home 216 N.Main St.Federalsburg, Md. 21632

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBRO VASCULAR ACCIDENT — 10 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Daughter's Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D0053815

29d. Date signed *(Month, Day, Year)*: 8/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Korah M. Pulimood, M.D. 510 South 5th Ave. Denton, md. 21629

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 15 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Catherine A. Thompson
CJ
01-4761-031

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27459

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Catherine Anne Thompson
2. Date of Death: Month: August; Day: 19; Year: 2001
3. Time of Death: 00:25 A.M.
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 212-86-9055
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 40 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Aug 28, 1960
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2815 Cabin Creek Drive
10f. Zip Code: 20866
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Excercise rider
16b. Kind of Business/Industry: horse racing

17. Father's Name *(First, Middle, Last)*: Ralph Eugene Gibson
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Anne Bryan

19a. Informant's Name/Relationship *(Type, Print)*: Michelle Berardi /daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2815 Cabin Creek Drive, Burtonsville, MD 20866

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mark's Cemetery
Date: 8/22/01
20c. Location - City or Town, State: Highland, Maryland

21. Signature of Funeral Service Licensee: M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: 8/18/01
28b. Time of Injury: 11:34 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Pedestrian struck by auto
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Roadway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Route 29 and Briggs Chaney Road Silver Spring, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 21 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

dad

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 27460
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ANTHONY VIGLIOTTI
2. Date of Death Month Day Year: AUG 17 2001
3. Time of Death: 12:00 PM
4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 174-16-6135
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 24 1914
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 14901 Belle Ami Drive
10f. Zip Code: 20707
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943/69
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Soldier
16b. Kind of Business/Industry: US Army

17. Father's Name *(First, Middle, Last)*: James Vigliotti
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Street

19a. Informant's Name/Relationship *(Type, Print)*: Sumie Vigliotti/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14901 Belle Ami Drive, Laurel, MD 20707

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Ivy Hill Cemetery
Date: 8/20/2001
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — 4 YEARS

Due to (or as a consequence of):
b. END STAGE RENAL DISEASE — 4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. SEPSIS 2° TO STAPHYLOCOCCUS — 1 WEEK

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0053150
29d. Date signed *(Month, Day, Year)*: AUGUST 18TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNTALA GUPTA MD 201-109 BACK RIVER NECK RD BALTIMORE 21221

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 21 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12+1 old

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27461

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY E VALENTINE
2. Date of Death Month Day Year: AUG 15 2001
3. Time of Death: 6 37 PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 402 16 8960
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): May 15, 1921
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8438 Jopenda Drive
10f. Zip Code: 21043
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [ ] No If Yes, Give Yaar or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Paper Maker
18b. Kind of Businass/Industry: Paper

17. Fathar's Name (First, Middle, Last): Lee Valentine
18. Mother's Name (First, Middle, Meiden Sumame): Catherine Campbell

19a. Informant's Name/Relationship (Type, Print): Alta Valentine/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8438 Jopenda Drive Ellicott City, MD 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Crest Lawn Cemetery
Date: 8-18-2001
20c. Location - City or Town, State: Marriottsville, MD

21. Signatura of Funeral Service Licensee: ▶ Sherma Collins - Wtyke M01044
22. Name and Address of Facility: Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death)
a. SEPSIS — WEEKS

Due to (or as a consequence of):
b. PNEUMONIA — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Liva birth 2 [ ] Fetal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of daath 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contributa to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of daath? 1 [ ] Yes 2 [ ] No

25. Was case relerred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurrad at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Physician MD
29c. License number: D42892
29d. Date signed (Month, Day, Yeer): AUG 15 2001

30. Nama and address of person who complated cause of daath (Item 23a) (Typa, Print): FRANCIS CHVIDIAN 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): AUG 17 2001
32. Registrar's Signature: ▶ Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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CJJ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27462

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Richard Waters
2. Date of Deeth (Month, Day, Year): August 4, 2001
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street end number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-20-6825
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 3, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 Victoria Court, Goldsorough
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes: WWII
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner & Operator
16b. Kind of Business/Industry: Rubber Company
17. Father's Name (First, Middle, Last): Burns Harcourt Waters
18. Mother's Name (First, Middle, Meiden Surneme): Ruth Woodward Williamson
19a. Informant's Neme/Relationship (Type, Print): Mrs. Judy S. Waters (Wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2 Victoria Ct., Goldsborough, Reisterstown, MD 21136
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Druid Ridge Cemetery
Date: 8/14/01
20c. Location - City or Town, State: Pikesville, MD
21. Signature of Funeral Service Licensee: ▶ Brian K. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final diseese or condition resulting in death): a. pneumonia
Due to (or as e consequence of):
Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditione** contributing to deeth but not resulting in the underlying cause given in Part I.: Ischemic cardiomyopaeby. peripheral vascular disease Emphysema

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and pleca, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Nico Hoh
29c. License number: 14 43974
29d. Date signed (Month, Day, Year): August 11, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nico Hoh 5401 old Court Road Northwest Hospital Randallstown, MD 21133

**State Registrar**

31. Dete filed (Month, Dey, Year): AUG 14 2001
32. Registrar's Signature: ▶ Jenna B Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

WJL 14+1VA

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27463

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM F. WINTERLING JR

2. Date of Death (Month, Day, Year): AUGUST 13 2001

3. Time of Death: 1005

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 213-14-1763

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 7,1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 108 Hall Drive

10f. Zip Code: 21804

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plant Manager

16b. Kind of Business/Industry: Can manufacturing

17. Father's Name (First, Middle, Last): William F. Winterling Sr.

18. Mother's Name (First, Middle, Maiden Surname): Myra Twigg

19a. Informant's Name/Relationship (Type, Print): Frances M. Winterling/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Hall Dr., Salisbury, MD 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park

Date: 8/15/01

20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: Keith R Dewey CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

8/13/01 10:05

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ischemic bowel & perforation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction

Renal failure

COPD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0053394

29d. Date signed (Month, Day, Year): AUGUST 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTHONY FREY, M.D. 1315 S. DIVISION ST. SALISBURY, MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

William F. Winterling

8+1VA DQ

01-4570-009
mnmr
Alexander Wilkinson

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27464

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Orville Alexander Wilkinson, Jr.

2. Date of Death (Month, Day, Year): August 09, 2001

3. Time of Death: 2310 pm

4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 213-42-9422

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 14, 1943

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: S. Carolina

10b. County: York

10c. City, Town or Location: Rock Hill

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1879 Springsteen Road

10f. Zip Code: 29730

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesman

16b. Kind of Business/Industry: telecommunications

17. Father's Name (First, Middle, Last): Orville Alexander Wilkinson, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Linnae Colleen Russell

19a. Informant's Name/Relationship (Type, Print): Christopher A. Wilkinson, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6905 So. MD Blvd., Owings, MD 20736

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Harmony Cemetery

Date: 8-16-01

20c. Location - City or Town, State: Owings, MD 20736

21. Signature of Funeral Service Licensee: William R. [illegible]

22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 8/9/01

28b. Time of Injury: 2340 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Driver in vehicular accident

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): Rte 4/Nursery Rd.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CARSON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 15 2001

32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

## Certificate of Death

Reg. No. 2001 27465

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Henrietta White

2. Date of Death: Month August Day 5 Year 2001

3. Time of Death: 2344 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 219-05-3295

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): 8-28-1921

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Quantico

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6020 CatchPenny Road

10f. Zip Code: 21856

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: XXX

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ColdWater Seafood

16b. Kind of Business/Industry: Seafood Industry

17. Father's Name (First, Middle, Last): Robert Washington Barclay

18. Mother's Name (First, Middle, Maiden Surname): Pearl Jurusha Bardlay

19a. Informant's Name/Relationship (Type, Print): Diane Bivens daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2619 Spring Lane Nanticoke,Md. 21840

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Nanticoke Cemetery Data: 8-11-01

20c. Location - City or Town, State: Nanticoke,Md

21. Signature of Funeral Service Licensee: C. Kevin Messick III M00416

22. Name and Address of Facility: Messick Funeral Home PO BOX 61 Bivalve, MD. 21814

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE

Due to (or as a consequence of): b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. ___

Due to (or as a consequence of): d. ___

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ___ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: COLON CANCER

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): ☒1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051743

29d. Date signed (Month, Day, Year): 08/05/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID SECHER, M.D. 100 E. CARROLL ST. SALISBURY, MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8/5/01 2344

Henrietta White 219-05-3295

5DQ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27466

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mabel Beatrice Yohn

2. Date of Death: Month August Day 8 Year 2001

3. Time of Death: 11:45PM

4a. Facility Name (If not institution, give street and number): Golden Age Guest Home

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 216-48-4577

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.19, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3240 Marston Rd.

10f. Zip Code: 21157

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Navar Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐Yas 2☒No Specify:

14. Rece - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): farm wife/homemaker

16b. Kind of Business/Industry: grain farming

17. Fathar's Nama (First, Middle, Last): William DallasLovell

18. Mother's Nama (First, Middle, Maiden Surneme): Ida Blanche Slonaker

19a. Informant's Name/Relationship (Type, Print): William Yohn III/ son

19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda): 3240 Marston Rd. Westminster, MD 21157

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or othar place): St. James Cemetery | Data: 8/11/01

20c. Location - City or Town, State: Dennings, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Nama and Address of Facility: Hartzler Funeral Home, 310 Church St. New Windsor, MD 21776

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Expires 11:45pm 8/8/01

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that ceused the daath. Do not anter tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one ceuse on aach lina.

Approximate Intarval Between Onsat and Death

Immediate Ceusa (Finel disaasa or condition resulting in death)

a. PRIMARY Degenerative Dementia — >1 YR.

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseese or injury thet initiated evants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of ceusa of death? 1☐Yas 2☒No

25. Was casa rafarred to medical examiner? 1☐Yas 2☒No

26. Placa of Death (Check only ona): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Rasidance 6☐Othar (Specify)

27. Mannar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Yohn, Mabel name known to physician

29a. Certifiar (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signeture and title of certifier: Patrick Turners

29c. Licansa number: D20806

29d. Date signed (Month, Day, Year): 8/9/01

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): PATRICK TURNES, MD SUITE 102, 1000 LIBERTY RD ELDORSBURG, MD 21784

WJT 5

**State Registrar**

31. Data filed (Month, Day, Year): AUG 14 2001

32. Registrar's Signatura: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27467

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HARRY ALBERT YOUNG
2. Date of Death (Month, Day, Year): AUGUST 11, 2001
3. Time of Death: 1:55 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 218-34-3826
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 26, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 320 East "A" Street
10f. Zip Code: 21716
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1957-1979
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: Fire/Safety Equipment

17. Father's Name (First, Middle, Last): Harry Young, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Helen Dyer

19a. Informant's Name/Relationship (Type, Print): Mrs. Eunice C. Young, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 320 East "A" Street, Brunswick, Md. 21716

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, Aug. 14, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard E. [illegible] M00255
22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church St., Frederick, Md. 21701

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Extensive Esophageal Ca | 4 wks |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia, obstructive jaundice

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D14626
29d. Date signed (Month, Day, Year): Aug 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PG Resch 501 W 7th St Frederick MD 21701

**State Registrar**

31. Date filed (Month, Day, Year): AUG 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Michael Amici
CJ
01-4778-045

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27468

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MICHAEL CHARLES AMICI, JR.
2. Date of Death — Month: August; Day: 18; Year: 2001
3. Time of Death: 00:50 A.M.
4a. Facility Name *(If not institution, give street and number)*: Peninsula Regional Medical Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 206-92-8265
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 22 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: APRIL 18, 1979
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: DELMAR
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: ROUTE 1 BOX 201 A
10f. Zip Code: 19940
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES CLERK
16b. Kind of Business/Industry: FOOD SERVICE INDUSTRY

17. Father's Name *(First, Middle, Last)*: MICHAEL CHARLES AMICI, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: DIANA M. RUTTER

19a. Informant's Name/Relationship *(Type, Print)*: DIANA M. RUTTER / MOTHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: ROUTE 1 BOX 201A DELMAR, DELAWARE 19940

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: AMERICAN CREMATION SERVICES
Date: August 23, 2001
20c. Location - City or Town, State: WARWICK, PENNSYLVANIA

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson, Jr. #m00612
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GUNSHOT WOUND (1) OF NECK AND CHEST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: 8/17/01 found
28b. Time of Injury: unknown M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Subject was shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Outside a residence
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 3200 block Old Ocean City Road Wicomico County, MD

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27469

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Anderson
2. Date of Death (Month, Day, Year): August 27, 2001
3. Time of Death: 240 A M
4a. Facility Name (If not institution, give street and number): 2424 W. FRANKLIN ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 104-12-4565
6. Sex: 1 ☐ M 2 ☑ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 15, 1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2424 W. FRANKLIN ST.
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH
College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENTERTAINER
18b. Kind of Business/Industry: NIGHT CLUBS

17. Father's Name (First, Middle, Last): EMERY LEATHERMAN
18. Mother's Name (First, Middle, Maiden Surname): LOUISE M. JONES

19a. Informant's Name/Relationship (Type, Print): COLETTA R. HORTON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2424 W. FRANKLIN ST. BALT. MD. 21223

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO
Date: AUG. 29, 2001
20c. Location - City or Town, State: CATONSVILLE MD.

21. Signature of Funeral Service Licensee: Steve W. Wood
22. Name and Address of Facility: GARY T. MARCH FUNERAL HOME INC 270 FREDHILTON PASS BALT. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic non small cell lung cancer — Approximate Interval Between Onset and Death: 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Julie R Brahmer MD
29c. License number: D0051770
29d. Date signed (Month, Day, Year): August 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie R Brahmer MD The Johns Hopkins Hospital Baltimore MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 7 per fh G798 082901 SS

## Certificate of Death

Reg. No. 2001 27470

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Henry Britton
2. Date of Death Month Day Year: August 17, 2001
3. Time of Death: 1540
4a. Facility Name (If not institution, give street and number): 2105 Vermont Avenue
4b. City, Town, or Location of Death: Landover
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 227-58-5052
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 ~~58~~ Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/23/1944
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2105 Vermont Avenue
10f. Zip Code: 20785
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Carroll Britton
18. Mother's Name (First, Middle, Maiden Surname): Vernen Peterson

19a. Informant's Name/Relationship (Type, Print): Vivian Britton/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2105 Vermont Ave. Landover, MD 20785

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 8/23/01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Alston Funeral Service 5525 Marlboro Pike #8 Forestvill, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac Arrythmia
Due to (or as a consequence of):
b. Hypertensive Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus; Chronic Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. T.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): Aug. 18th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27471

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Data of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| JEAN | | BLICKSTEIN | AUGUST 23 2001 | 1:55 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MILFORD MANOR NURSING HOME | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-38-9656 | 1☐ M 2☒ F | 90 Yrs. | | | APR 25 1911 | MONTANA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2 HIGHSTEPPER COURT APT. 604 | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | SALES | REAL ESTATE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SAMUEL LADON | ESTHER (UNKNOWN) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EDWARD BLICKSTEIN/ SON | 2 HIXSON COURT MONTVILLE, NEW JERSEY(07045) |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | ANSHE EMUNAH-AITZ CHAIM CONGREGATION | 8/26/2001 | BALTIMORE, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael Krug | SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208 |

**Physician /Medical Examiner**

26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MYOCARDIAL INFARCTION | 5 MIN |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Dehydration

| 23a. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D33974 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur D. Goldberg 6804 Pine Heights Ave Balto, Md 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | ▶ Sandra D. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27472

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH BRIDGETT

2. Date of Death (Month, Day, Year): August 22, 2001

3. Time of Death: 0113

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 238-26-7610

6. Sex: X M 2 F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 3, 1924

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: X 1 Yes 2 No

10e. Street and Number: 404 Bryant Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lumber Worker

16b. Kind of Business/Industry: Colbern Lumber Co.

17. Father's Name (First, Middle, Last): Ransom Bridgett

18. Mother's Name (First, Middle, Maiden Surname): Elleaner Raynor

19a. Informant's Name/Relationship (Type, Print): Dorothy B. Johnson-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 W. Lexington Street Balto. MD 21223

20a. Method of Disposition: X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cem.

Date: 8/28/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Brenda McLean

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

**Physician Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 2 hours

Due to (or as a consequence of): b. Hypertension — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer Dementia, Diabetes Mellitus, Anemia

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29e. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: BG5848998

29d. Data signed (Month, Day, Year): August 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): St. Agnes Hospital Robert Greenwald MD 900 Caton Avenue Baltimore md 21229

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001

32. Registrar's Signature: ▶ Brenda P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BRIDGETT, JOSEPH

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27473

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DOLORES GESSLER BROWN

2. Date of Death Month Day Year: AUGUST 25, 2001

3. Time of Death: 07:00 AM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-14-5822

8. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 26, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 10535 York Road Apt. 213

10f. Zip Code: 21030

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian

18b. Kind of Business/Industry: Library

17. Father's Name *(First, Middle, Last)*: Robert A. Gessler

18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Horstmann

19a. Informant's Name/Relationship *(Type, Print)*: Teresa Pascal (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3805 Ridge Knoll Ct. 107-B Fairfax, Virginia 22033

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cemetery

Date: 8-28-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George H. Ferrante

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BILATERAL PNEUMONIA — 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joginder P Mehta M.D.

29c. License number: D41410

29d. Date signed *(Month, Day, Year)*: August 25th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27474

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Carol | Louise | Bates | August 20, 2001 | 6:50AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Roland Park Place | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-20-0930 | 1☐M 2☒F XX | 87 Yrs. | | | November 24, 1913 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☐Yes 2☐No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 830 West 40th Street | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| XX 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes XX 2☒No If Yes, Give Year or Dates: | 1☐Yes XX 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Medical Secretary | Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Clarence Wilson Bates | Estelle Boucher |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George Thomsen PR | 1 North Charles Street Suite 400 Balto MD 21201 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| XX 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Druid Ridge Cemetery | 8/27/01 | Pikesville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Donna Stephenson Menakes | Mitchell-Wiedefeld Fun Hm Inc 6500 York Road Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | 5 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes XX 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes XX 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: XX 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| XX 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) XX 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Frederick W. Iglehart III MD | D33400 | 08/21/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Iredell W. Iglehart III MD 500 W University Pkwy Baltimore MD 21210

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | Sandra B. Sparks |

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMENDED ITEM#5 per fh G803 010402 ss AMENDED ITEM#11 per inf G800 101501 ss

Reg. No. 2001 27475

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): KEITH M. CHRISTMAS
2. Date of Death (Month, Day, Year): August 5, 2001
3. Time of Death: 7:40 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: ~~580-42-2727~~ 580-02-2727
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/13/1954
9. Birthplace (State or Foreign Country): Nevis, W.I.

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3028 Bel Pre Road #301
10f. Zip Code: 20916
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed ~~4 [ ] Divorced~~
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
18b. Kind of Business/Industry: Hotel/Restaurant

17. Father's Name (First, Middle, Last): Joseph Christmas
18. Mother's Name (First, Middle, Maiden Surname): Helena Claxton

19a. Informant's Name/Relationship (Type, Print): Rhonda Christmas/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 528 Thayer Ave. Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington
Date: 8/17/2001
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Alston Funeral Service 5525 Marlboro Pike #8 Forestville, MD 20747

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cardiomyopathy — 1995

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last
Due to (or as e consequenca of):
b. CHF Congestive Heart Failure — 1995
Due to (or as a consequence of):
c. HBP - Hypertension — 1995
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D17729
29d. Date signed (Month, Day, Year): August 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George B. Patrick MD 9221 Colesville Rd Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27476

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helena A. Clark
2. Date of Death (Month, Day, Year): 8/23/2001
3. Time of Death: 11:20PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-01-1460
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/4/1903
9. Birthplace (State or Foreign Country): Baltimore, Md

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7717 Bradshaw Road
10f. Zip Code: 21087
10g. Citizen of What Country: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Her own Home
17. Father's Name (First, Middle, Last): George Weber
18. Mother's Name (First, Middle, Maiden Surname): Catherine Killian
19a. Informant's Name/Relationship (Type, Print): Clark Scott (grandson)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7701 Bradshaw Rd. Kingsville, Md 21087
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Parkwood Cemetery — Date: 8/27/2001
20c. Location - City or Town, State: Baltimore, Md
21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md 21087

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 8/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

AUGUST 23, 2001 11:20 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

HELENA A. CLARK

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMND ITM#5 PR. F.H. G799 9-6-01 JAB

Reg. No: 2001 27477

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| DOROTHY COX | AUGUST 22, 2001 | 5:53 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Frederick Memorial Hospital | Frederick, MD | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 233-34-3140 | 1☐ M 2☒ F | 77 Yrs. | | | 3/22/1924 | Charlestown, WV |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| PA | York | Hanover, PA 17331 | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1301 Brad Drive | 17331 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Dept. of Juvenile Services | State Gov't |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Abraham Isaac Jacob Snyder | Maude Beard |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Randy Cox | 1301 Brad Drive, Hanover, PA 17331 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Marburg Memorial Gardens | 8/27/01 | Hanover, PA |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Joseph V. Fingling — # CC0362 | WETZEL FUNERAL HOME, INC. 549 Carlisle Street, Hanover, PA 17331 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. INTRACRANIAL HEMORRHAGE | 2 DAYS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D44213 | 8/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVI YALAMANCHILI FREDERICK MEMORIAL HOSPITAL FREDERICK MARYLAND

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | ▶ B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

#5
#30

Frederick Memorial Hospital

X 77

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27478

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH E. COLLINS

2. Date of Death Month: August Day: 25 Year: 2001

3. Time of Death: 9:39 AM

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital 2401 West Belvedere Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-24-2047

6. Sex: 1☐ M 2☑ F

7. Age *(in yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-27-1920

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 2331 BRADDISH AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INSURANCE AGENT

16b. Kind of Business/Industry: INSURANCE

17. Father's Name *(First, Middle, Last)*: CHARLES LEE

18. Mother's Name *(First, Middle, Maiden Surname)*: JEANETTE ROSS

19a. Informant's Name/Relationship *(Type, Print)*: JEANETTA GREEN

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5946 GREEN MEADOW PKWY, BALTO MD 21209

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CROWNSVILLE CEMETERY

Date: 09-01-01

20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung cancer

Due to (or as a consequence of):

Brain metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d. Sepsis syndrome

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: Res 000

29d. Date signed *(Month, Day, Year)*: August 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Adelaida T. Ortiz 2401 West Belvedere Avenue Baltimore Maryland 21215

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Collins E Elizabeth E

4

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27479

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| LEE GARNETT COLEMAN, SR. | 08-26-2001 | 10:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 5901 LEEWOOD AVENUE | CATONSVILLE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-01-4511 | 1 ☐ M 2 ☑ F | 88 Yrs. | | | 12-12-1912 | VA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | CATONSVILLE | 1 ☐ Yes 2 ☑ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5901 LEEWOOD AVENUE | 21228 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2 ☑ No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12TH GRADE | N/A | STEEL GRINDER | ARMCO STEEL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LEE GARNET COLEMAN | ROSA WRIGHT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CRYSTAL COLEMAN | 5907 LEEWOOD AVE., CATONSVILLE MD. 21228 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | LOUDON PARK | 8-31-2001 | BALTO. MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Vaughn C Greene | VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Pneumonia | 1 wk |
| Due to (or as a consequence of): b. | Carcinoma Prostate with ANASARCA | 1 yr |
| Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D25044 | 8/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. REHMAN 2717 Hammonds Ferry 21227

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | Regina D Sparks |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27480

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JOAN KLEIN CARLSON | August 27, 2001 | 2:17 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. Joseph Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-36-6505 | 1☐M 2☒F | 64 Yrs. | | | Jan. 16, 1937 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Lutherville | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 19 Bramleigh Rd. | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | Home maker | Own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Paul Klein | Elsie Lillian Amos |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. John W. Carlson/husband | 19 Bramleigh Rd. Lutherville, MD 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Hilltop Service Corp. | 8/28/01 | Towson, MD |

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in death) | a. Electromechanical Dissociation | |
| Due to (or as a consequence of): | b. Respiratory failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. Congestive Heart Failure | 1 week. |
| Due to (or as a consequence of): | d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Adult onset diabetes mellitus

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Francis L Wiegmann Jr MD | D25569 | 8/28/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Francis L. Wiegmann, Jr M.D. 1205 York Rd. #11 Lutherville, Md. 21093

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | D. Sparks |

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27481

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Alice Clark
2. Date of Death: Month August Day 26 Year 01
3. Time of Death: 12:30 am
4a. Facility Name *(If not institution, give street and number)*: Stella Maris
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-30-6744
6. Sex: 1☐ M 2☐ F xx
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-08-10
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Timonium
10c. City, Town or Location: Dulaney Valley
10d. Inside City Limits: 1☐ Yes xx No
10e. Street and Number: 2300 Dulaney Valley Road
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Give Yaar or Datas: xx
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): High School; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeping
16b. Kind of Business/Industry: private homes

17. Father's Name *(First, Middle, Last)*: John Hall
18. Mother's Name *(First, Middle, Maiden Surname)*: Saddie Peaker Hall

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Gorman
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11212 48 East 96th Street Apt#2R Brooklyn, NY

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Pk. Cem.
Date: 08-30-01
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: ▶ Debra E. Hoke
22. Name and Address of Facility: Baltimore, Maryland 21215 WM.C. March, West 4300 Wabash Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease — Years

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Type II Diabetes Mellitus; Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case rafarred to medical examinar? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at the time, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ernestine Wright, MD
29c. License number: D52740
29d. Data signed *(Month, Day, Year)*: August 27th, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Ernestine Wright, Fairhaven, 7200 3rd Avenue, Sykesville MD 21784

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #10a,b,c,d,e&f PER EH 6799 9/07/01 JH

# Certificate of Death

Reg. No. 2001 27482

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Franklin Donald Christhilf | August 25 2001 | 2:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6100 Bellinham Ct., Apt. 1031 | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-24-3457 | 1[X] M 2[ ] F | 73 Yrs. | | | June 10, 1928 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| ~~Maryland~~ OREGON | ~~Baltimore~~ CLATSON | ~~Baltimore~~ CANNON BEACH | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| ~~6100 Bellinham Ct., Apt. 1031~~ 352 SUNSEY BLVD.P.O.BOX1099 | ~~21210~~ 97110-1099 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | minister | religious |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Franklin Chase Christhilf | Florence Wheeler |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra Christhilf/wife | 6100 Bellinham Ct., Apt. 1031 Baltimore, MD 21210 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | Greenmount Crematory | Aug. 28,2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John O. Mitchell IV | Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ADVANCE MYELODYSPLASIA | 1 YEAR |
| Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1[ ] Yes 2[X] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant et time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown | 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medical exeminer? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[ ] Yes 2[X] No | Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| B Douglas Smith MD | D0047398 | AUGUST 28, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
B. DOUGLAS SMITH 1650 ORLEANS STREET BALTIMORE MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | L. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

$10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#11 PR. F.H. G799 9-6-01 JAB

# Certificate of Death

Reg. No. 2001 27483

PATIENT KNOWN AS ROSALIND YVONNE DOUGLAS

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Rosalind Y. Douglas
2. Date of Death (Month, Day, Year): AUGUST 25 2001
3. Time of Death: 6:26 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 212-82-8408
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-05-61
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3324 Hayward Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: Disabled

17. Father's Name (First, Middle, Last): Frederick Douglas, I.
18. Mother's Name (First, Middle, Meiden Surneme): Hattie Pressley

19a. Informant's Name/Relationship (Type, Print): Frederick & Hattie Douglas
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3520 Manchester Avenue Baltimore, Maryland 21215

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem.Pk. Cem.
Date: 08-30-2001
20c. Location - City or Town, Stete: Randallstown, MD

21. Signature of Funeral Service Licensee: Jerome A. Thompson
22. Name and Address of Facility: Baltimore, Maryland 21215 WM.C.March, West 4300 Wabash Avenue

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY DISTRESS SYNDROME
Due to (or as a consequence of):
b. PNEUMOCYSTIS CARINII PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ACQUIRED IMMUNODEFICIENCY SYNDROME
END STAGE RENAL DISEASE
DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Omolara Smith
29c. License number: RES-000
29d. Dete signed (Month, Day, Yeer): AUGUST 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): OMOLARA SMITH MD SINAI HOSPITAL OF BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: [illegible]

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#11

DHMH 17 Rev 1/2001

ORIGINAL

01-4882-510
cm
Unknown 01-224
Vernon Eney

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27484

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Vernon H. Eney

2. Date of Death — Month: August; Day: 25; Year: 2001

3. Time of Death: 12:40 P.M.

4a. Facility Name *(If not institution, give street and number)*: Mile Post 100

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-24-9494

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: March 27 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 435 Yale Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Person

16b. Kind of Business/Industry: Hospital/Apartments

17. Father's Name *(First, Middle, Last)*: LeRoy Albert Eney

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Cora Strahler

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn J. Eney / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 435 Yale Avenue, Baltimore, Maryland 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cramatory or othar place)*: Bayview Crematory

Date: 8/27/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert tellure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☑ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* at scene

27. Menner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 8/25/01

28b. Time of Injury: 12:40PM

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred: Subject jumped in front of oncomong Train

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Train Tracks

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Mile Post 100 Baltimore, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: August 26, 2001

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001

32. Registrer's Signeture

---

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

RR

RR 6+1

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27485

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Anna M. Engel | August 25 2001 | 1:20 P.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care Rossville | Baltimore | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-07-1210 | 1☐ M 2☒ F | 89 Yrs. | | | Aug 11 1912 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9803 Oak Park Drive | 21236 | United States |

| 11. Marital Status | 12. Was Decedent Ever In U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Critzman | Katherine Brenner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James Critzman / Nephew | 9803 Oak Park Drive, Baltimore, Maryland 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge Mem. Park | 8/28/01 | Elkridge, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Juanita R Thomas | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Possible aspiration pneumonia | |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. malnutrition | |
| Due to (or as a consequence of): | | |
| | c. | |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Anemia

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D48271 | 8-25-01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FAHED KOULE MD 7600 Osler Dr. Suite 411 Towson, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Anna Engel DOD 8/13/1912 SS# 215-07-1210 RR 5 ex. 128pmm

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 27486

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PAULINE GROFT

2. Date of Death Month Day Year: AUGUST 21, 2001

3. Time of Death: 7:20 AM

4a. Facility Name *(If not institution, give street and number)*: 209 E. Baltimore Street

4b. City, Town, or Location of Death: Taneytown

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 216 22 9210

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 15, 1927

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 209 E. Baltimore Street

10f. Zip Code: 21787

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☐ No *Specify:* unknown

14. Rece - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): none

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: shoe assembly

16b. Kind of Business/Industry: Shoe factory

17. Father's Neme *(First, Middle, Last)*: Charles U. Flickinger

18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary E. Heltibridle

19a. Informent's Neme/Reletionship *(Type, Print)*: Douglas Groft/son

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 927 Frazzelburg Rd., Uniontown, MD 21158

20a. Method of Disposition: 1☐ Burieł 2☐ Cremetion 3☐ Removel from Stete 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*

Dete

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CA — 1 1/2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was casa referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Flavio Kruter MD

29c. License number: D35394

29d. Dete signed *(Month, Day, Year)*: 8-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FLAVIO KRUTER - 555 S. CENTER ST. WESTMINSTER, MD 21157

**State Registrar**

31. Date filed *(Month, Day, Year)*: AUG 29 2001

32. Registrar's Signature: Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27487

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNA M. HARMS
2. Date of Death Month: AUGUST Day: 28 Year: 2001
3. Time of Death: 9:30 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: —

**Funeral Director**

5. Social Security Number: 218-26-5224
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 29, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7355 Furnace Branch Road
10f. Zip Code: 21060
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
18b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): George Snyder - Son-in-Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 Severn Road, Millersville, Maryland 21108-1206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery | Date: 9/4/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — Approximate Interval Between Onset and Death: > 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CARDIAC ARRHYTHMIA — 1 DAY
Due to (or as a consequence of):
c. CEREBROVASCULAR ACCIDENT — 71 year
Due to (or as a consequence of):
d. HYPERTENSION — 71 year

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
— DEMENTIA
— ANEMIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Attaphol Pawarode HOUSE OFFICER
29c. License number: P15585
29d. Date signed (Month, Day, Year): August 28, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ATTAPHOL PAWARODE HARBOR HOSPITAL, BALTIMORE, MD 21225

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: James B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 27488

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Virginia C. Hawkins | August 26, 2001 | 11:05p |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Villa St. Michaels | Baltimore | NA |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-62-8081 | 1☐M 2☒F | 53 Yrs. | | | 05-20-48 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1☒Yes 2☐No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1423 Mullin Court | 21231 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th Grade | NA | Home Maker | in home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Leonard Hill | Marjorie Boston |

| 19a. Informent's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward Hawkins | 5622 Woodmont Avenue Baltimore, Maryland 21239 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify) | King Mem. Pk. Cem. | 09-01-01 | Randallstown, MD |

| 21. Signeture of Funerel Service Licensee | 22. Neme and Address of Facility |
|---|---|
| ▶ Bernard D Johnson | Baltimore, Maryland 21202 WM.C.March FH ,East 1101 E. North Ave. |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in deeth)

a. Metastatic cancer.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that inifieted events resulting in death) Last

b. Prepundeome

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnency | 23d. Dete of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

| 23e. Did tobacco use contribute to the cause of deeth? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of deeth? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Wes cesa referred to medical exeminer? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ [signature] | D0053593 | 8/29/01. |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mostafa St. Joseph Hospital O'Day Medical Arts Building 2nd.FL. Suite #208

**State Registrar**

| 31. Date filed (Month, Dey, Yeer) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | ▶ Geneva M Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

De'vin M. Hicklin
CJ
01-4893-510

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27489

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| DE"VIN HICKLIN | August | 26 | 2001 | 07:03 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215 53 4430 | 1☐M 2☐F X | 3 Yrs. | | | 8/22/98 | MD. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD. | | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3602 ROBERTS PLACE | 21224 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Yeer or Dates: X | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | 0 | none | none |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM HICKLIN | TAMIKA S. THOMAS |

| 19a. Informent's Neme/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| TAMIKA S. THOMAS | 3602 ROBERTS PL. BALTO. MD. 21224 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | KING,S PARK | 8/30/01 | RANDALLSTOWN, MD. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| CECIL A. ESTEP Cecil A Estep | ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PL. BALTO. MD. 21217 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BLUNT FORCE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical exeminer? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | 8/21/01 | 9:58 PM | 1☐Yes 2☒No | Subject beaten |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Residence | 1708 Cameron Road Baltimore, Maryland |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner steted.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Laron Locke M.D. | O.C.M.E. | August 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrer's Signeture |
|---|---|
| AUG 29 2001 | G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS#24a,25,26,27,29a per phys G798 082901 ss

# Certificate of Death

2001 27490
Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia C. Holmes
2. Date of Death Month Day Year: August 14, 2001
3. Time of Death: 244PM
4a. Facility Name (If not institution, give street and number): Asbury
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 579282976
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/30/26
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: CALVERT
10c. City, Town or Location: SOLOMONS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11750 Asbury Circle
10f. Zip Code: 20688
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: State Department

17. Father's Name (First, Middle, Last): Robert Garland Chandler
18. Mother's Name (First, Middle, Maiden Surname): Marine Womack

19a. Informant's Name/Relationship (Type, Print): Asbury/Solomans Retirement Ctr
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11750 Asbury Circle Solomans, MD 20688

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, Md 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43306
29d. Date signed (Month, Day, Year): 8/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sylvia Batong MD, 11100 Asbury Circle, Solomons, MD

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: Geneva D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27491

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Allen W. Harris

2. Date of Death: Month August Day 26 Year 2001

3. Time of Death: 1553

4a. Facility Name (If not institution, give street and number): 178 Chesapeake mobile Ct.

4b. City, Town, or Location of Death: Hanover

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 206-32-2692

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 25,1944

9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Hanover

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 178 Chesapeake Mobile Court

10f. Zip Code: 21201

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1964-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Bakery

17. Father's Name (First, Middle, Last): Max Harris

18. Mother's Name (First, Middle, Maiden Surname): Bessie Martin

19a. Informant's Name/Relationship (Type, Print): Dawn D. Harris (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7831 Spencer Road, Glen Burnie, MD 21060

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 08/29 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Michele J. Kutta

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Chronic Obstructive Lung Disease years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy MD

29c. License number: D06054

29d. Date signed (Month, Day, Year): 8/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001

32. Registrar's Signature: Regina P Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

25

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27492

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| HELEN MARIE HART | August 27, 2001 | 6:15A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-32-2463 | 1☐ M XX F | 75 Yrs. | | | August 3, 1926 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1☐ Yes 2☒ No XX |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 210A Rogers Forge Road | 21212 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced XX | 1☐ Yes 2☒ No XX If Yes, Give Year or Dates: | 1☐ Yes 2☒ No XX Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Supervisor | Temp Agency |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John August Scheurich | Helen Marie Gannon |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elizabeth Dannettel DTR | 1422 Mayberry Road East Westminster, Maryland 21158 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial XX Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify) | Greenmount Cemetery | 8/28/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis Stephen Knake | Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ADENOCARCINOMA of the LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown | 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fatal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PEPTIC DUODENAL ULCER 8/17/01

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? 1☐ Yes 2☒ No | 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No |
|---|---|

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | D07132 | 8/27/2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Maffezzoli MD 515 Fairmount Avenue Suite 330 Towson MD 21286

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | [signature] G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27493

Patient known as FERN HENDERSON!

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FERN LOUISE HENDERSON
2. Date of Death: Month August Day 25 Year 2001
3. Time of Death: 10:30 A M
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 217-54-0136
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-4-1951
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: WINDSOR MILL
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8109 SUBET RD.
10f. Zip Code: 21244
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): -12- College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SOCIAL SECURITY BENEFITS
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): LUCIUS W. LEEPER
18. Mother's Name (First, Middle, Meiden Surname): NOLA SIMPSON

19a. Informant's Name/Relationship (Type, Print): LEONARD HENDERSON JR(HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8109 SUBET RD. WINDSOR MILL, MARYLAND 21244

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY
Date: 8-31-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Dunwoody L Redd
22. Name and Address of Facility: REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
**Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)
a. METASTATIC SQUAMOUS CELL CARCINOMA OF THE PELVIS

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Last
b. Due to (or as e consequenca of):
c. Due to (or as a consequenca of):
d.

Approximete Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Othar (specify) 9 ☐ Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Omolara L. Smith MD
29c. Licanse number: RES-000
29d. Date signed (Month, Day, Year): August 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OMOLARA L. SMITH, MD SINAI HOSPITAL OF BALTIMORE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: Jennie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27494

PATIENT KNOWN AS ELSIE JOHNSON

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELSIE ROBINNETTE JOHNSON
2. Date of Death: Month AUGUST Day 26 Year 2001
3. Time of Death: 2:38 AM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-28-9849
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7112 Marston Road
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: AT&T

17. Father's Name (First, Middle, Last): Maceoa Cruz
18. Mother's Name (First, Middle, Maiden Surname): Leola E. Jones

19a. Informant's Name/Relationship (Type, Print): Keith P. Redmond
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15818 Wayne Avenue Laurel, Maryland 20707

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 8/30/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Chas L Blake
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. COMPLETE BOWEL NECROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnent in the pest 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnency: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical exeminer? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and menner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chudan Sit MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): AUGUST 26 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): OMOLARA SMITH MD SINAI HOSPITAL OF BALTIMORE

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

130

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#4b,c per phys G798 082901 SS.dnb AMEND ITEM#19b per fh G798 082901 ss

# Certificate of Death

Reg. No. 2001 27495

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| JOAN A. JONES SR | 08 / 11 / 01 | 0800 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| St. AGNES HEALTHCARE | BALTIMORE | ~~BALTIMORE CITY~~ N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-34-5580 | XX M 2 F | 63 Yrs. | | | 05 21 38 | M.D. |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2767 West North Ave | 21217 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married XX Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes XX No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th grade | na | Truck Driver | Truck Company |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Wallace Jones | Gertrude Turner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruth Jones-Wife | 2767 West North Ave, Baltimore Md 21216 ~~21217~~ |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) / Date | 20c. Location - City or Town, State |
|---|---|---|
| XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Arbutus Memorial Park 8/17/01 | Arbutus, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Lynette K. Jones | March F/H West 4300 Wabash Ave, Baltimore Md 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Hypertrophic dilated Cardiomyopathy | yrs |
| Due to (or as a consequence of): b. | Coronary artery disease | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c. | Hypertension | yrs |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Attending Pathologist Melissa Burke | D36765 | 8/13/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melissa Burke MD St Agnes Healthcare 900 Caton Ave Balt. MD

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | Geneva D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME John A. Jones Sr.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

2001 27496
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| William Bal Karalfa | 08 / 24 / 2001 | 0658 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| ST. AGNES HOSPITAL | BALTIMORE | n/a |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-28-9102 | 1 X M 2 F | 68 Yrs. | | | Jan 21, 1933 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1 Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2910 Sollers Point Road | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 X Divorced | 1 X Yes 2 No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | 0 | Millwright | Mfg. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Joseph F. Karalfa | Mary E. Doyle |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Harold Russell / Brother-in-law | 5512 Channing Road, Baltimore, Maryland 21229 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Md. Veterans Cemetery | 8/27/01 | Crownsville, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| R.N.C.A. | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. RESPIRATORY FAILURE | ONE DAY |
| Due to (or as a consequence of): | b. SEVERE METABOLIC ACIDOSIS | TWO DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. ACUTE RENAL FAILURE | THREE DAYS |
| Due to (or as a consequence of): | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Data of delivery Month / Day / Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC LIVER DISEASE

SEVERE SEPSIS

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 Yes 2 X No | 1 Yes 2 X No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 Yes 2 X No | Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MEDICAL RESIDENT | P14440 | 08-24-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAKARI ALIYU MD. ST. AGNES HOSPITAL, BALTIMORE, MD 21229

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME KARALFA, WILLIAM R

RR 12f1

UNIVE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar REPLACEMENT **Certificate of Death** Reg. No. 2001-27497

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| NATHANIEL | KNOTTS | | 08 / 23 / 2001 | 0340 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS BAYVIEW MED. CTR. | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 240-52-7132 | 1☒M 2☐F | 64 Yrs. | | | 03-07-1937 | NORTH CAROLINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | | BALTIMORE | 1☑Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1516 NATIONAL ROAD | 21237 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | MECHANIC | BALTIMORE GAS + ELECTRIC |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CLINTON KNOTTS | GEORGIE STEWART |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SHIRLEY V. KNOTTS (WIFE) | 1516 NATIONAL ROAD BALTIMORE, MD 21237 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | PARKWOOD CEMETERY | 8-27-01 | BALTIMORE, MARYLAND |

| 21. Signature of Funeral Service License | 22. Name and Address of Facility |
|---|---|
| [signature] MD1015 | VAUGHN C GREENE 4905 YORK RD. BALTIMORE MD 21212 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):
b. MULTI-ORGAN SYSTEM FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. SEPSIS

Due to (or as a consequence of):
d. END-STAGE RENAL DISEASE

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29e. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D56867 | 9/27/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JA SOSA MD BAYVIEW MEDICAL CENTER

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| OCT 04 2001 | ▶ [signature] |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To Be Completed by Physician/Medical Examiner**

**Medical Certification;**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27498

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles Randall Keller
2. Date of Death: Month August, Day 28, Year 2001
3. Time of Death: 3:32 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 166-14-2308
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): January 12, 1915
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4108 Pinedale Drive
10f. Zip Code: 21236
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor (Land Acquisition)
16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): Franklin Adam Keller
18. Mother's Name (First, Middle, Maiden Surname): Katherine McCoy

19a. Informant's Name/Relationship (Type, Print): Margaret W. Keller (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4108 Pinedale Drive Perry Hall, Maryland 21236

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Dunmore Cemetery
Date: 9/1/2001
20c. Location - City or Town, State: Dunmore, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Steven T. Zittle
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert feiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finei disease or condition resulting in death)
a. non-small cell concer of Lung — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last
b.
Due to (or es e consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. Licansa number: D25205
29d. Date signed (Month, Day, Year): August 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley MD MMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: ▶ Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

0332 AM
8/28/01
Keller, Randall
Dy-15

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 27499

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| DORA | | KATZ | AUGUST 24 2001 | 12:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GENESIS BRIGHTWOOD | LUTHERVILLE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 119-20-1680 | 1☐ M 2☒ F | 92 Yrs. | | | MAY 16 1909 | NY |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | TIMONIUM | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2139 CHAPEL VALLEY LANE | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | BUYER | RETAIL |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| BARNETT NELSON | IDA (UNKNOWN) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. BARBARA SHILLING/DAUGHTER | 2139 CHAPEL VALLEY LANE TIMONIUM, MD. 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | 20c. Location - City or Town, State |
|---|---|---|
| 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify) | HILLSIDE(MT. ZION SEC. 8/26/01 | LYNDHURST, NJ. |

21. Signature of Funeral Service Licensee ▶ Michael Kruger

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

**Physician /Medical Examiner**

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic Obstructive Pulmonary Disease | Unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ MD | D27569 | 8/24/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Heffleman 1838 Green Tree Rd 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| AUG 29 2001 | ▶ Jeanne D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 27500

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ADELE MARIE LOMBARDO
2. Date of Death: Month August Day 27 Year 2001
3. Time of Death: 3:00 a.m.
4a. Facility Name (If not institution, give street and number): 604 S. Shramrock Rd.
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 213-05-5707
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 604 S. Shramrock Road
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Sheck
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Zinn

19a. Informant's Name/Relationship (Type, Print): Anthony Lombardo (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 604 S. Shramrock Rd. Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns.
Date: 8/30/01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert M. Kratz
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Rd. Balto. Md. 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of the Colon

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D26637
29d. Date signed (Month, Day, Year): 8/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRY [illegible] MD 7600 OSLER DR #311 TOWSON MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): AUG 29 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

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**Medical Certification: To Be Completed by Physician/Medical Examiner**